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JANUARY 1973

Volume 49

Number 1



Editorial —

What's Wrong With Pharmacy Service In Nursing Homes?

Maintaining Professional Competency—An Assessment Of The Challenge

by Clifton J. Latiolais

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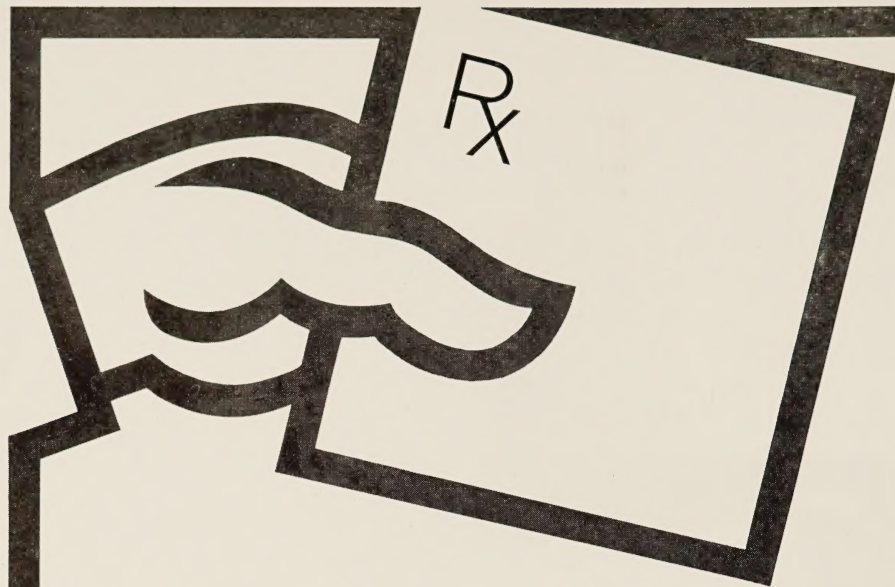
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650 WEST LOMBARD STREET
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Editorial . . .

What's Wrong With Pharmacy Service In Nursing Homes?

Section 242 of the recently enacted Social Security Act Amendments of 1972 makes kickbacks and bribes by pharmacists to nursing homes subject to criminal sanctions. Section 242 states in part:

"Whoever furnishes items or services to an individual for which payment is or may be made under this title and who solicits, offers, or receives any kickback or bribe in connection with the furnishing of such items or services . . . shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$10,000.00 or imprisoned for not more than one year or both."

These acts are, of course, violations of the Maryland and American Pharmaceutical Code of Ethics, as well as the Maryland Pharmacy Law, with suspension or revocation of license as penalties.

For years, pharmacists have been complaining that the selection of a particular pharmacy by the owners of many nursing homes to provide pharmaceutical service is based upon considerations other than quality of service and facilities, qualifications of personnel, professional accomplishments, experience, or similar appropriate criteria.

There have been allegations that by pressure or "suggestion," pharmacists have had to "kickback" a significant part of their fees in order to obtain or retain the patronage of many (some say most) nursing homes.

We believe it is not in the best interest of either the patient or the person, private insurer or governmental agency (the taxpayer) for the nursing home to have a vested interest in how much medication or how many dollars of medication a patient receives. What incentive is there for nursing home owners, administrators or staff to facilitate and effectuate drug utilization controls if the profit to the nursing home increases as the prescribing (or perhaps the mere billing) of medication increases?

If a nursing home incurs an expense in the administration of pharmaceutical services, the costs involved should be computed and included in the per diem patient charge. The return to the owners of a nursing home should not be tied to the number of prescriptions or dollar amount of medication.

We are, therefore, opposed not only to any rebate or kickback scheme, but to any "discount" or percentage charge for "service" to the pharmacy for collection, billing or any other activity. In the end, it is the private patient or the taxpayer who will finance these reprehensible kinds of schemes to exploit the providing of health care to a group of vulnerable captive patients.

And now an insidious cancer has developed with the acquisition of community pharmacies by nursing

home corporations. Here again, is serious potential conflict of interest. Where proprietary nursing homes are served and "billed" by a pharmacy which is owned and controlled by the nursing home, the opportunities for exploitation of patients and the elimination of "checks and balances" provides unlimited potential for getting away with "murder."

Pharmacists involved in these kinds of enterprises expose themselves as participants in unethical, unprofessional and possible illegal activities.

The Maryland Pharmaceutical Association will do everything legally possible to assure that patients of nursing homes and related institutions receive pharmaceutical services of the highest quality, and at the same time prevent financial exploitation of any party involved, while preserving the professional integrity of all pharmacists.

—Nathan I. Gruz

PHARMACY CALENDAR

March 8 (Thursday) — Maryland Society of Hospital Pharmacists meeting at Maryland General Hospital.

March 18-24—National Poison Prevention Week.

March 22 (Thursday)—Baltimore Metropolitan Pharmaceutical Association Meeting at Quality Courts Motel, Reisterstown Road.

March 28 (Wednesday)—University of Maryland School of Pharmacy Alumni Association Dinner at Valley Country Club, Towson.

April 12 (Thursday)—Maryland Society of Hospital Pharmacists meeting at Union Memorial Hospital.

April 26 (Thursday) — Spring Regional Meeting, Maryland Pharmaceutical Association, Friendship International Hotel, Friendship Airport.

May 15 - 21—Maryland Pharmaceutical Association. Fiesta in Spain. Convention and tour.

June 15 - 17—Eighth Annual Hospital Pharmacy Seminar—Maryland Society of Hospital Pharmacists, Diplomat Motel, Ocean City, Maryland.

June 29 - July 1—91st Annual Convention, Maryland Pharmaceutical Association, Hunt Valley Inn, near Baltimore.

July 21-27—American Pharmaceutical Association Annual Meeting, Boston, Massachusetts.

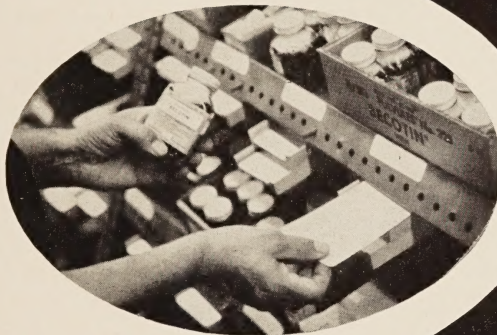
December 9 - 13—American Society of Hospital Pharmacists Midyear Clinical Meeting, New Orleans, Louisiana.



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Maryland Board of Pharmacy News

Pharmacy Changes

The following are the pharmacy changes for the month of January:

New Pharmacies

Giant Pharmacy No. 230, J. B. Danzansky, President; Route 40 and Baughman's Lane, Frederick, Maryland 21701.

No Longer Operating As Pharmacies

Kinnamon & Briele, Inc., Clifford A. Hare, Jr., President; 801 Park Avenue, Baltimore, Maryland 21201.

Drug Fair No. 52, Milton L. Elsberg, President; 2451 Chillum Road, Hyattsville, Maryland 20782.

Metro Drugs, Leo Goldfeder, President; 4880 Boiling Brook Parkway, Rockville, Maryland 20853.

Metro Drugs of Southern Md., Inc. (Riverdale Pharmacy), Leo Goldfeder, President; 6222 Baltimore Boulevard, Riverdale, Maryland 20840.

Beitler's Pharmacy, Leonard Beitler, 4300 Ritchie Highway, Baltimore, Maryland 21225.

Changes of Ownership, Address

Bambrick's Pharmacy, Inc., Vincent Bambrick, President (Change of ownership); Race and Cedar Streets, Cambridge, Maryland 21613.

The Drug Listing Act of 1972

from the American Pharmaceutical Association
Legal Division

The Drug Listing Act of 1972, which amends the drug registration section (§510) of the Federal Food, Drug and Cosmetic Act, generally requires all producers of drug products to file as "drug establishments" with the FDA a list of all drugs that they compound or manufacture. The purpose of the Drug Listing Act is to provide the FDA with a current, comprehensive list of drugs available for sale in the United States.

Drug products compounded in a pharmacy for dispensing by prescription are exempt from the Act. Also exempt are drug products supplied by a pharmacy to individual licensed prescribers for use in the course of their professional practices. However, pharmacies that compound or manufacture a drug product for widespread general sale to licensed prescribers are required to register. If a pharmacy compounds or manufactures a prescription-legend drug product for sale to other pharmacies, that pharmacy must register the drug product. If a pharmacy compounds or manufactures an OTC drug product for sale to other distributors or the general public, the pharmacy must register that drug product.

If a pharmacist is uncertain whether he may be required to register a drug product under the Act, he may

contact the FDA directly, state the facts in his particular case, and request a ruling. For inquiries write: Division of Industry Liaison, Office of Compliance, Bureau of Drugs, Food and Drug Administration, 5600 Fishers Lane, Rockville, Maryland 20852.

Registration Under the Act

The establishment will register on an FDA Form "Registration of Drug Establishment and Drug Listing." This form is obtainable on request from the Department of Health, Education and Welfare, Food and Drug Administration, 5600 Fishers Lane, Rockville, Maryland 20852 or from the Food and Drug Administration district offices.

The effective date of the Drug Listing Act is February 1, 1973. The initial listing is required during the month of June, 1973. Thereafter, updating information is to be submitted once during the month of December and once during the month of June of each year. These semiannual updates need include only new drugs, notification of any material change in previously submitted information, and notice of discontinuation of any drug. The FDA plans to exempt by regulation the submission of duplicate drug listing data by those firms that have supplied the information via the earlier conducted voluntary information survey.

Summary of Required Information

<i>Class of Drug</i>	<i>Required</i>	<i>Required Upon Request*</i>
(1) Human new drugs Drugs containing insulin Certifiable antibiotics New Animal drugs.	Reference to authority for marketing. Copy of all labeling.	List of each drug product that contains a particular ingredient.
(2) Human prescription drugs other than those listed in No. 1 above.	Quantitative listing of active ingredients. All labeling. Representative advertisements.	All advertisements for a particular drug product. Quantitative listing of all ingredients for a particular drug product. List of each drug product that contains a particular ingredient.
(3) Human non-prescription drugs. Not new veterinary drugs.	Quantitative listing of active ingredients. Labels. Package inserts. Representative samples of other labeling.	Quantitative listing of all ingredients for a particular drug product. List of each drug product that contains a particular ingredient.

**If necessary to carry out the purposes of the Act.*

Licensed practitioners who prepare drugs for use in their professional practice and manufacturers preparing or processing drugs solely for use in research, teaching, or chemical analysis and not for sale are exempt from the Act. Other classes of persons may be exempted by FDA regulation.



Legend drugs in their own time

University of Maryland School of Pharmacy

University of Maryland Hospital Institutes Unit Dose System, Intravenous Admixture Laboratory Formally Opened.

Ribbon-cutting ceremonies were held at two locations at the University of Maryland Hospital recently. In ceremonies held at the new satellite pharmacy of the Patient Care Pharmacy Service, a new and efficient program of individualized drug administration was officially launched. The new unit dose system eliminates several steps involved in the ordering, delivery and administration of medications, cutting down on time, expense, and the possibility of error.

Currently, 75 per cent of all hospital medications are handled by the Patient Care Pharmacy Service, and with the March opening of the new north hospital wing, all patients will be covered by this service. The unit dose system is maintained from three satellite station pharmacies located on the third, tenth, and eleventh floors. Each station is prepared to meet the drug needs of two floors of the hospital and they operate from 7:30 a.m. until 11 p.m. weekdays, and 7:30 a.m. to 4 p.m. weekends.

The new system allows the pharmacist to serve the patient more directly and helps cut down on medication costs. With individualized dosage, the patient pays only the cost of medication he takes. Another advantage of the unit dose system is the time saved in nursing hours. According to Dr. Peter P. Lamy, Director of Institutional Pharmacy Programs, nursing personnel spent about 30 per cent of their time dispensing medications, but this time has been cut to an estimated five or six per cent, liberating nurses to concentrate more fully on treatment of the patient. Responsibility for the Patient Care Pharmacy Service rests with Arthur Riley, Project Director, and Vincent de Paul Burkhart, Assistant Chief of Pharmaceutical Services.

On January 30, 1973, Dr. George Yeager, Director, University Hospital and Dr. William J. Kinnard, Jr., Dean, School of Pharmacy, participated in the opening of the Intravenous Admixture Laboratory. The specially trained staff, under the supervision of Mrs. Pearl Walsh, currently provides service to the third, fourth, ninth, tenth, eleventh, and twelfth floors of University Hospital, seven days a week, averaging about 50,000 bottles of admixtures per year.

The laboratory is the result of close cooperation between the Hospital and the School of Pharmacy. The School's facilities, instrumentation, and expertise that support this patient service include such items as temperature and humidity recording devices, a Dynac portable automatic particle monitor, Raynier air slit samplers, and a thermo-anemometer. In addition to patient service, this facility has been assigned a role in the School's

Pharmacists at University Hospital Awarded Roche Grant

Roche Laboratories recently awarded a Hospital Pharmacy Grant to Paul C. Welk, III and Vincent de Paul Burkhart of the University of Maryland Hospital for their work with audio-visual aids in providing patient education.

The project will encompass production and testing of many types of patient instruction aids. These aids will help the patient to understand particular disease processes and to visualize the use of specific drugs and devices in the treatment of these conditions.



Paul C. Welk, III, Pharmacy Resident and Vincent de Paul Burkhart, Assistant Chief Pharmacist (3rd and 4th from left respectively) of the University of Maryland Hospital receive Hospital Pharmacy Grant from Roche Laboratories representative Clifford Crown. Looking on is George H. Yeager, M.D., Director of University of Maryland Hospital.

teaching function, instructing pharmacy and nursing students.

A third important function is continuing research. Several projects are currently under way. One is the continuous testing of the environment as an indicator and possible predictive agent for the assurance of sterility of all products. Another, conducted in cooperation with the Baltimore Cancer Research Center, is concerned with the metabolism of drugs in patients kept in Life Islands.

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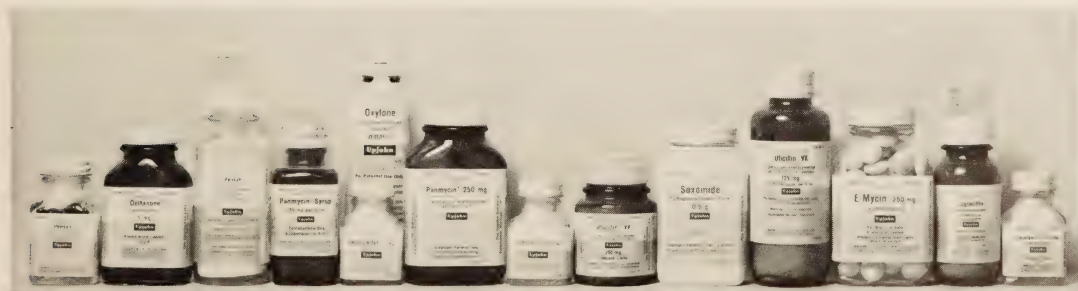
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Maintaining Professional Competency — An Assessment Of The Challenge

By

Clifton J. Latiolais*

President, American Pharmaceutical Association

Introduction

Maintaining the competency of the health professional is widely recognized as one of the more critical problems within our health care system. In a dynamic, fast pace age where knowledge can become obsolete almost overnight, the health professional must practice life long education in order to provide the best possible health care to his patient and to society.

Educational authorities tell us that today's graduate will be totally out of date in one decade unless he maintains an ongoing continuing education program. This is a frightening statement to any new graduate, even more so to an older graduate because he may possess a 10 year old, or worse yet, even a 20 or 30 year old degree. If he does possess such a degree, the question is whether he is still competent or not.

It is certainly important for teachers, administrators, lawyers, bankers and the other professionals to maintain their competency. But it is crucial and essential for a health professional (physician, nurse, pharmacist) to maintain his professional competency. For a patient's life is *in balance* if he is not competent. Thus, there is no question that the public *expects* the health professional to maintain competency throughout his career. The challenge, therefore, is to develop an effective means of maintaining this competency for hundreds of thousands of health practitioners.

External pressures motivate the health professional to try to keep up. These pressures come from threats of malpractice, agency regulations or relicensure requirements, public demand and federal concern. Consumer consciousness will force every health profession to examine its responsibilities within the health care system and to redefine its competencies. Unquestionably, the forces are great and quality control of professional competency seems inevitable. The difficult questions are what should be done, how should it be done and who should do it.

Analysis of Current Competency of The Profession

The 1971 edition of *Health Resources Statistics: Health Manpower and Health Facilities* (National Center for Health Statistics, Department of HEW) reports a total of 129,287 pharmacists in active practice in the United States during 1971.

*Presented as the 1972-73 Andrew G. Dumez Lecture, the University of Maryland School of Pharmacy, Baltimore, Md., October 17, 1972.

Mr. Latiolais is Associate Professor and Director, Department of Pharmacy, The Ohio State University Hospitals, Columbus, Ohio.

The following data shows the number of graduates from colleges of pharmacy prior to and after 1960:

Prior to 1960	— 83,347 (64%)
1960-1965	— 20,604 (16%)
1966-1971	— 25,336 (20%)
	<hr/>
	129,287 (100%)

An analysis of this data would indicate that only about one third of the practitioners have graduated within the past decade. One might reasonably assume that they are all still professionally competent while the other two thirds might not. This however, would depend on the extent to which they kept up to date through some continuing education programs.

However, let's look at these data in a little different perspective. Certainly, the graduates prior to 1960 did not receive any biopharmaceutics, pharmacokinetics, contemporary pharmaceutics and current pharmacological principles. These subjects (namely biopharmaceutics and pharmacokinetics) were simply not taught before 1960. Between 1960 and 1965 some of this material began to emerge in only a very few schools; physical pharmacy was more in vogue during this period. Thus, it is only since 1965 or so that graduating pharmacists began to receive sufficient education in these subjects to be able to apply these principles in practice. And then it has been only within the past 3 or 4 years that a few schools began to develop clinical pharmacy to any perceptible and meaningful depth. Even today in 1972 a large percentage of the 74 Colleges of Pharmacy have not achieved this essential goal.

Thus, only the recent graduates have received sufficient in depth education in biopharmaceutic and pharmacokinetic principles to be able to competently apply them in practice. Therefore, a logical question can be raised about the 80% of the pharmacists in the United States who graduated prior to 1965 with regard to their present professional competency in biopharmaceutics, pharmacokinetics, contemporary pharmacology and clinical pharmacy.

Has a logically, and sequentially structured continuing education program been developed, implemented and evaluated to bring these 104,000 pharmacists up to date on these subjects to make them professionally competent? I submit that no such program exists. Surely, numerous half day, 1 day, 2 day or longer seminars or institute programs have been given on some of these general subjects, but in a very piecemeal way. It would be interesting to find out how many (or I should say how few) of these pharmacists could even give a decent definition of

the term pharmacokinetics, let alone understanding the scientific principles underlying the subject and, even more important, knowing how to apply these principles in actual practice situations involving an individual patient's drug therapy regimen.

While I have no specific data to substantiate or to refute this interesting hypothesis, I submit my gut feeling through extensive experience in practice and in knowing colleagues throughout the United States that only a small percentage of these pharmacists could apply these principles in practice.

While this may be a serious indictment, what good is it to attempt to bury the problem? That would be a total innocent and unpardonable travesty on the indictment.

What we need to do is:

- (1) to intelligently assess the problem
- (2) to logically develop a solution
- (3) to methodically implement the program
- (4) to honestly evaluate its effectiveness and
- (5) to modify the continuing program on the basis of the findings.

Legal Requirements For Continuing Education In Pharmacy

In 1967, The Florida and Kansas Boards of Pharmacy initiated legal requirements for continuing education in order for pharmacists to be eligible for licensure renewal each year. Since that time, other states have initiated similar requirements, namely, Ohio, California, and New Jersey.

The motivation for developing this legal requirement in Florida may have been based on the influx of semi-retired pharmacists moving into the state. On the other hand, current trends in other states leads one to suggest that some state pharmaceutical associations and Board of Pharmacy are supporting mandatory continuing education because this will provide them with needed income through fees derived from seminars and other continuing education meetings. This, I suggest, is a gross disservice to the pharmacist, to the profession and to the public.

In reviewing the present mandatory continuing education program in the several states, there is nothing to suggest that sufficient planning has taken place to:

1. Properly define continuing education for relicensure.
2. Outline what measures should be applied to determine professional competency.
3. Outline the essential elements of continuing education programs for pharmacists to maintain their professional competency.
4. Outline the criteria for accepting or rejecting seminar or meeting topics for credit toward relicensure.

5. Outline the criteria to be used for assigning credit value for different types of continuing education topics at meetings, seminars, self study programs, etc.
6. Evaluate (through appropriate testing procedures) the effectiveness of the training programs by the pharmacists.

Thus, in the absence of a clearly defined program with specific objectives and appropriate criteria for evaluation, I'm afraid that mandatory continuing education for pharmacy was grossly premature and ill advised. With such ill defined objectives, legal requirements for relicensure can only breed mediocrity at best and will inevitably lead professional "competency" to its lowest possible common denominator. Thus, the profession should take a second and more critical look at mandatory continuing education. It seems as though the profession has jumped into the "mandatory" stream with both feet, but perhaps without the head. What other alternatives have been considered? For example, evaluating professional competency by the peer review process and through voluntary challenge examinations in specialty areas has excellent merit, provides enthusiastic challenge and develops a voluntary willingness to learn in contrast to the forced, involuntary, legal approach. There is no documentation that voluntary alternatives are not more desirable than the mandatory (legal) approach to continuing education.

What Is Being Done

What then, is being done to develop an effective national program to help pharmacists maintain their professional competency? It is true that a number of organizations, colleges, associations and other groups are doing many individual things to help the practitioner. While these efforts are admirable, there is no coordination, no logical planning of the overall effort, no systematic implementation of these fragmented plans, no evaluation of their effectiveness, etc.

In 1970 the AACP adopted the following resolution:

"Be it resolved, that the AACP recommend to the NABP and to the APhA that a tripartite committee be established with membership from each organization to conduct such studies and to make such recommendations as would be appropriate for the development of programs and the adoption of legislation to make continuing education mandatory for licensure renewal."

Such a tripartite committee was formed and it submitted a report in 1971 and in 1972. The 1972 report submitted at the Houston APhA meeting pointed out the following important point:

"The committee wishes to emphasize that it is not making recommendations on the questions of the appropriateness of, or the need for, requiring pharmacists to meet a minimum requirement of continuing education before relicensure is granted.

It acknowledges that these questions are still open to debate and that decisions on this matter must still be made by the concerned professional associations, particularly at the state level. It also notes, however, that there is a growing development of interest in an increasing number of states, following the lead of Florida and Kansas, to make participation in continuing-education programs a requirement for relicensure of pharmacists."

This statement alludes to the position taken at the 1970 APhA House of Delegates which adopted the recommendation of its Professional Affairs Committee that a background paper on mandatory continuing education be prepared *prior to the development of a position on the question*. The profession has not, as yet, taken a position on whether mandatory continuing education is the right approach to take or not.

Thus, in light of these and other problems the Board of Trustees of the APhA at its July 11-12, 1972 meeting voted:

"That the president be instructed to arrange a leadership conference on continuing education, to include representatives of pharmacy organizations with demonstrated interest in continuing education for pharmacists, for the purpose of determining how these organizations can cooperatively proceed in fulfilling the respective mandates by their memberships in the area of continuing pharmacy education."

Subsequent to this action, I, as President of the APhA, have invited each of these organizations to designate representatives to attend such a leadership conference on continuing education. Each of these organizations has accepted the invitation, appointed its representatives and has agreed to attend a leadership conference which is scheduled for October 23, 1972. Thus, it is the sincere hope of the APhA that this conference will be successful in uniting the profession to develop the type of coordinated program which American pharmacy has needed for so long.

Another program which has direct bearing on continuing education and professional competency is the emerging professional roles which pharmacists are expected to assume. Thus, the APhA Board of Trustees adopted the following motion:

"That the president appoint an ad hoc committee including representatives of the AACP, ACPE and ASHP to outline a format for a study to consider the needs of the profession brought about by emerging, innovative practitioner roles which might be undertaken by a special commission."

I have responded to this action by appointing an *Ad Hoc Committee* to study these emerging innovative practitioner roles. Such a study will effect both the undergraduate pharmaceutical educational curriculum and also the continuing education needs of the practitioner.

Who Should Assume Responsibility

Back in 1948, the Elliott Survey recommended that Colleges of Pharmacy and Boards of Pharmacy assume responsibility for implementing continuing education for the profession. Here we are a quarter of a century later in practically the identical posture we were in 1948 on the lack of an effective plan to maintain professional competency of the practicing pharmacist.

I do not agree with the approach recommended in the Elliott Survey. Obviously it has not been effective. It should not be the responsibility of Boards of Pharmacy to plan and implement continuing education programs. Boards currently control the setting of standards affecting the practice of pharmacy and many are doing a myopic job of it. The role of the Boards of Pharmacy should be to enforce the standards set by the profession. They should not set the standards. While the Boards must certify that a licensee in pharmacy must be a graduate of an accredited college of pharmacy it does not mean that the Board must operate the college of pharmacy and accredit it too. Boards of pharmacy are not in the business of undergraduate pharmaceutical education; nor should they be in the business of continuing pharmaceutical education.

The Colleges of Pharmacy do not have sufficient resources nor the organizational structure to do the job of continuing education alone. However, Colleges do have the scientific and clinical facilities and possess the expertise needed to educate the practitioner. They also know the content of the current curriculum as well as the curriculum content which was provided to former graduates.

Colleges of Pharmacy face many almost insurmountable problems in their ability to develop a coordinated, national program of continuing education for the practitioner. These factors include the independency of Colleges of Pharmacy, their alumni loyalty, their geographic location, their primary mission of undergraduate and graduate education, their attitude toward correspondence course study and on the job training programs, their restrictions on expenditure and availability of funds, their faculty attitude toward continuing education, the generation gap between academe and practice and their lack of authority over the profession both within the states and nationally.

While the AACP and the NABP have good intentions to provide the continuing education needs of the practitioner, neither organization, alone or jointly, has all the requisites to accomplish the job. The profession itself must assume responsibility for maintaining its own professional competency. Thus, the profession's organization—The American Pharmaceutical Association must assume basic responsibility for this broad mission. It does not have the insurmountable constraints of the boards, or of the Colleges, or of the segmented or specialty groups within pharmacy. Furthermore, there must be uniformity in the goals, the requirements, the evaluation process, etc. in order for pharmacists to be able to transfer their achievements from state to state.

VD prevention news

10 MILLIONTH "PLAIN TALK" V.D. PAMPHLET DISTRIBUTED

With V.D. on the climb throughout the world, it's comforting to note that the public is really getting the word on how to aid in its prevention. To date, Youngs



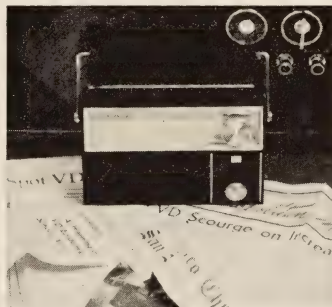
Here Mel Clark (left) Sales Manager, Youngs Drug Products Corp., presents 10 Millionth Pamphlet entitled "Plain Talk About V.D." to Virginia Governor Linwood Holton on the occasion of State's special "V.D. Awareness Month." Looking on are Thomas W. Rorer, President VPhA and Richard B. Lake, Chairman of Public Affairs Commission.

has printed and distributed over 10 million copies of the informative booklet entitled "Plain Talk About V.D."

ANOTHER YOUNGS ADVERTISING FIRST

In 1968 Youngs Drug Products Corporation created history as a prophylactic company by pioneering the first condom ad ever to run in a consumer magazine. And now they've done it again! In late 1972 and 1973

Youngs is sponsoring the first condom radio commercials ever to be aired in the U.S. A saturation program starting with a series of three, thirty-second prime drive time spots will be run on Black radio station WNJR. WNJR's New York and New Jersey market represents an audience of 1 3/4 million listeners to make up a lucrative market of over one billion

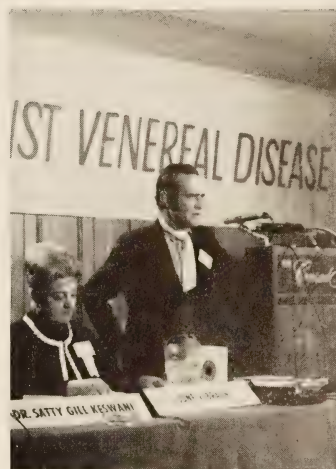


dollars annually. The cleverly written radio dialogue drives home the point that listeners should visit their pharmacist and ask for TROJANS, the number one drug-store brand.

NATIONWIDE "WOMAN'S WAR" WAGED AGAINST V.D.

Nearly 500 women members of WONARD (Women's Organization of NARD) convened in Chicago at the NARD Convention to organize a War on Venereal Disease. The new WONARD campaign will stress PREVENTION as the single, most important method to combat the nation's most serious

epidemic illness. Guest speakers at the V.D. symposium included Frank Santora, Chief of V.D. Information, New York City Department of Public Health, Dr. Satty Gill Keswani, India-born gynecologist and a specialist in the problem of infertility, Stephanie D. Radford, registered pharmacist from Washington State, and John C. MacFarlane (pictured above) president of Youngs Drug Products Corporation.



The importance of the meeting was attested by the fact that the three major TV news networks, ABC, CBS, and NBC covered the proceedings along with local Chicago TV and newspapers. One of the revealing facts that came up at the convention was that the nation's 130,000 pharmacists now comprise the most active organized bloc fighting venereal disease.

The national professional association is in a position to coordinate and implement a well planned, goal oriented continuing education program. In doing so, it would work with and utilize the vast resources available.

- (1) from all the Colleges of Pharmacy and their respective universities,
- (2) from the other health professions and their existing educational programs,
- (3) from the other specialty groups, state and local associations,
- (4) from the private continuing education industry and
- (5) from government agencies, philanthropic foundations and other resources interested in financially supporting such a coordinated program.

The basic and primary objective of this coordinated educational program *must be* to protect the public health and welfare by improving and maintaining the professional competency of the practicing pharmacist. This is a fundamental issue, because the existing continuing education programs carried out by colleges, associations or specialty groups have other primary objectives, such as improving alumni relations, fulfilling responsibilities to the members, raising additional income to help the association, or to help support faculty, improving the program in order to attract more members to attend the meetings, etc. With such diverse and unrelated objectives, a coordinated national program could not possibly succeed. Self interest of the individual or of the organization cannot be the primary objective—the interest of the public welfare must be paramount.

Achieving Professional Competency

Perhaps I should have discussed “achieving” professional competency before discussing “maintaining” professional competency. Certainly, it is the responsibility of the College of Pharmacy to help the pharmacy student achieve competency. In the past, this was accomplished through completing the school’s curriculum plus the internship which was outside the jurisdiction of the school.

The revised Accreditation Standards of the ACPE provide for the Schools of Pharmacy to be involved in the internship training. The Standards state:

“The Council believes that the experiences students gain in the clinical courses (including clerkships and internships) should be of such calibre so as to serve in lieu of the internship requirement for licensure. The Council expects, therefore that a curriculum be designed to include an externship and other clinical components that will lead to the degree of professional competence in students required for admission to the licensure examination.”

In the new standards the Council also states:

“The time normally required for the baccalaureate and doctoral degree programs is five and six academic years or the equivalent respectively, follow-

ing high school. In cases where the logistical and time conditions permit, students may complete either program in less time. When this occurs, students will have fulfilled the prescribed academic requirements and have demonstrated professional competence as judged by the faculty.”

An analysis of the two statements above leads one to raise the question as to how does a school of pharmacy determine when a student achieves professional competency. This is a rather basic and very important question for it seems to me that it should be answered before the other question of how to *maintain* one’s professional competency.

Thus, the current challenge to colleges of pharmacy is to determine what constitutes professional competency in its students. While I do not have a specific answer to this difficult question, I shall elaborate on the general approach which may be taken to arrive at an appropriate answer.

Perhaps I can use the following equation as an illustration:

$$\begin{array}{rcl}
 \text{GE} & + & \text{PBS} + \text{CP} = \text{PC} \\
 & & \text{General Education} \\
 & & \text{and} \\
 & & \text{Preclinical Services} \\
 & & + \\
 & & \text{Pharmaceutical Sciences} \\
 & & \text{Biomedical Sciences} \\
 & & \text{Social \& Behavioral Sciences} \\
 & & + \\
 & & \text{Clinical Sciences} \\
 & & \& \\
 & & \text{Patient Oriented Practice} \\
 & & = \\
 & & \text{Professional} \\
 & & \text{Competency}
 \end{array}$$

An oversimplification of professional competency means that a student has learned the preclinical and the pharmaceutical and biomedical sciences and through his general education plus his knowledge of the social and behavioral sciences he is able to apply these scientific and professional principles in a patient oriented practice situation. In order for the student to acquire this competency, there must be an effective coordination between the scientific faculty and the clinical faculty during the entire educational process. The culmination of this educational process is the clinical setting where the student is provided the opportunity to perform in observational practice situations. These situations provide both the scientific and clinical faculty to evaluate the student both in his knowledge of the scientific and professional principles and in his ability to apply these principles in practice. Successfully doing this should convince the faculty of the student’s professional competency.

There are inherent advantages to this approach compared to the existing educational structure all the way through the senior final exams. First, the exceptional

and hard working students could complete their program in a shorter period of time than the current mandatory five years; second, it would provide a more satisfactory evaluation of the student's ability to practice; third, it would insure a safe degree of competency to the public; fourth, it would eliminate the need for the existing ludicrous state board examinations; fifth, it would provide an acceptable measure of assessing the professional competency of the practitioner; sixth, it would provide a basis for structuring an appropriate and meaningful continuing education program for the practitioner; seventh, it would provide a basis for evaluating the effectiveness of the continuing education program; eighth, it would provide the proper credentialing to the state board of pharmacy of the student's competency and the practitioner's continued competency.

Now then, I want to return to an earlier statement that within one decade after graduation, a pharmacist will be totally outdated unless he keeps up. At the present time colleges of pharmacy have a specific charge of preparing undergraduate students to be competent practitioners. The total enrollment for the full five years in the 74 colleges is approximately 25,000 students. Thus, during a five year period that is the "workload" responsibility (if you will) of the colleges. But what about the 129,000 practitioners during this five year period. Don't you see the tremendous job we have to maintain the competency of these practitioners, because if this does not happen, they will be totally out of date and professionally incompetent in another five years.

I submit, therefore that the magnitude of the job in continuing education for the entire profession is as great, if not greater, than the job of educating the undergraduate pharmacy student.

While you students here at the University of Maryland are concerned with only 5 to 6 years to achieve professional competency, you will be faced with maintaining this competency during your entire professional lives. This means a total of about 40 years from age 25 to age 65. Imagine that, 4 long decades! Just like myself and your faculty, you also have an opportunity to come professionally incompetent 4 times during these 4 decades. Good luck!

Noxell Reports Record Sales, Earnings in 1972

Noxell Corporation reported record sales and earnings for 1972. Officials said progress had been made without acquisitions or price increases. Consolidated net sales for 1972 were \$83,502,000, an increase of 17.3 per cent over 1971.

The annual dividend rate was increased during the second quarter of 1972 to 40 cents per share. This was the maximum allowed by presidential guidelines, Noxell officials said. The 1973 budget of \$5 million includes \$2 million toward the expansion of warehouse facilities at the Cockeysville plant.

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Hospital Pharmacy Section

Maryland Society of Hospital Pharmacists

The January 11 meeting of the Maryland Society of Hospital Pharmacists was held at the Good Samaritan Hospital. Director of Pharmacy Patrick H. Birmingham, extended greetings and introduced the guest speaker, Dr. Mary Betty Stevens. Dr. Stevens, Assistant Professor of Medicine at the Johns Hopkins Hospital, spoke on current trends in the treatment of arthritis and connective tissue disease.

President Pellissier opened the business session and called for reports. Nominating Committee Chairman Samuel Lichter asked members who were planning to attend the ASHP annual meeting in Boston in July to inform him in order that they might be considered for election as delegate. Seminar Committee Chairman John Motsko announced the appointment of Larry Hogue as Seminar Publicity Chairman replacing Marsha Fruchtbau. Robert E. Snyder, Seminar Program Chairman, announced the list of speakers for the 1973 Seminar. A mailing will go out as soon as the entire list is confirmed. At the close of the meeting, President Pellissier thanked Schering Laboratories for their financial support towards the meeting.

Dr. Lamy To Receive W. Arthur Purdum Award From MSHP

Dr. Peter P. Lamy, Professor of Pharmacy and Director, Institutional Pharmacy Programs, University of Maryland School of Pharmacy and University Hospital, has been selected as the 1973 recipient of the W. Arthur Purdum Award. The award is named in honor of Maryland's pioneer in the development of hospital pharmacy, and an early leader and past president of the American Society of Hospital Pharmacists. The W. Arthur Purdum Award is presented on an annual basis to the person who has made the most significant or sustained contribution to hospital pharmacy in Maryland. The selection committee consists of past recipients of the award.

Dr. Lamy obtained his undergraduate and graduate degrees from the Philadelphia College of Pharmacy and Science. He was appointed Assistant Professor of Pharmacy at the University of Maryland School of Pharmacy in 1963, promoted to Associate Professor in 1966 and assumed his present duties in 1970. Dr. Lamy holds membership in numerous pharmacy organizations including the Maryland Pharmaceutical Association. He is a Past President of the Maryland Society of Hospital Pharmacists and has served as Vice-Chairman of the Committee on Research and Vice-Chairman of the Commission of the Council on Scientific Affairs of the American Society of Hospital Pharmacists.

He is currently Subpanel Chairman of the Drug Interaction Program of the American Pharmaceutical Association and is also participating in the Continuing Education Program of the American Society of Hospital Pharmacists by producing tapes in a series called Voices 12/60.

He is consultant to the U.S.P.H.S. Hospital in Baltimore, the Provident Hospital in Baltimore, Sound Management in Arizona and the Levindale Geriatric Hebrew Center and Hospital, Inc. and has been consultant to several pharmaceutical companies.

Dr. Lamy has presented papers at local, state, national and international meetings, and has lectured at many colleges and universities including American University, University of Rhode Island College of Pharmacy, University of Pittsburgh School of Pharmacy, University of Florida and Florida A & M University. He has written and published over 100 professional and scientific articles appearing in journals in the United States and several other countries. Additionally, Dr. Lamy is listed in American Men of Science.

As Co-Director of the Professional Experience Program of the School of Pharmacy, Dr. Lamy is responsible for the institutional part of that program. He is also responsible for the graduate program in Institutional Pharmacy.

The award will be presented at the Eighth Annual Hospital Pharmacy Seminar of the Maryland Society of Hospital Pharmacists, June 15-17 in Ocean City, Maryland.

Miss Heyer Installed as NCPG President

Miss Ursula E. Heyer, Chief Pharmacist at the Greater Baltimore Medical Center, was recently installed as 1973-1974 President of the National Catholic Pharmacists Guild of the United States at the NCPG Annual Meeting in Chicago. Miss Heyer, a Life Member of NCPG, was formerly Executive Secretary of the Guild.

A native of Germany, Miss Heyer came to the United States in 1947 and attended the University of Wisconsin School of Pharmacy where she obtained the B.S. degree in 1951. She obtained her M.S. degree from the University of Maryland School of Pharmacy in 1958. She served as Chief Pharmacist at the Johns Hopkins Hospital from 1960 to 1964 at which time she accepted the position of Chief Pharmacist at the Greater Baltimore Medical Center.

Since 1969, Miss Heyer has served on the Executive Committee of the Federation Internationale des

(Continued on Page 26)

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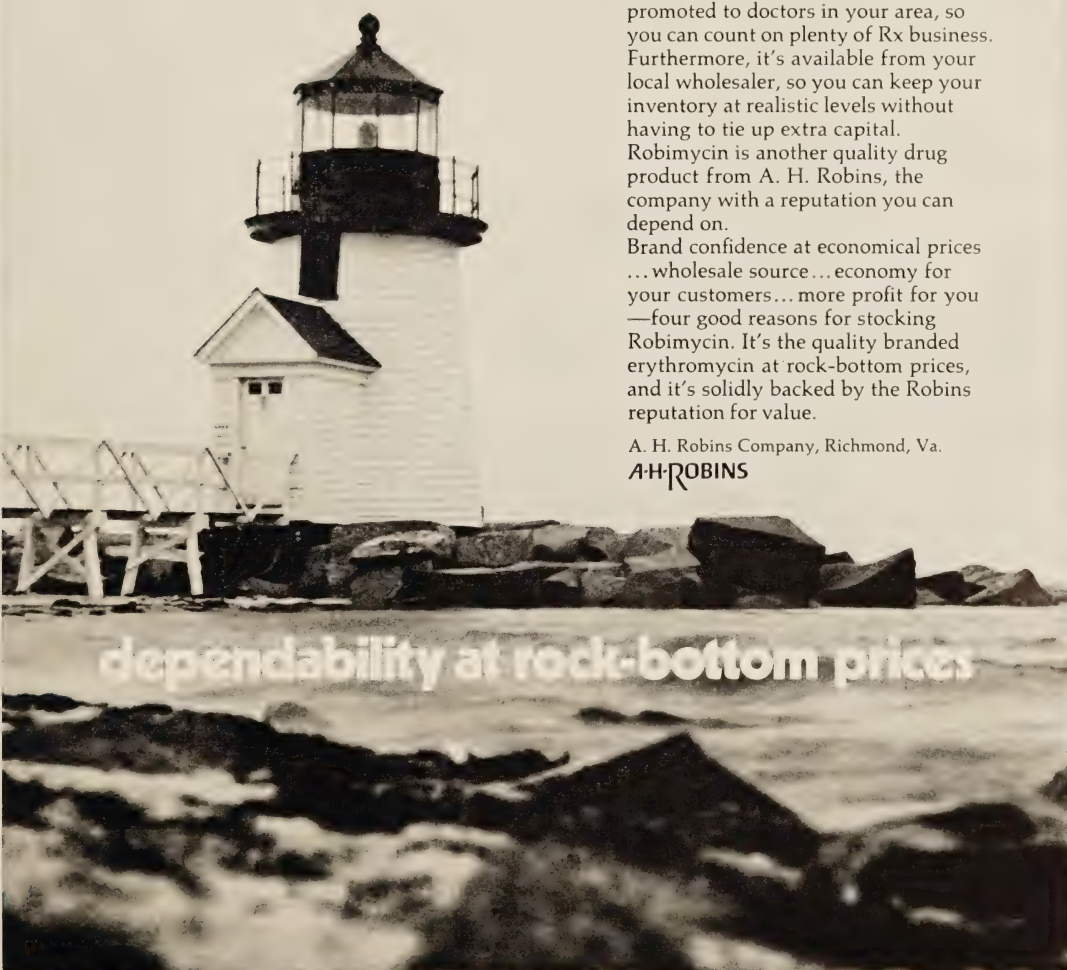
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Baltimore Metropolitan Pharmaceutical Association

Fifty-Seventh Annual Installation Banquet



Baltimore Metropolitan Pharmaceutical Association Fifty-Seventh Annual Installation Banquet and Dance, Blue Crest North, January 28, 1973. Upper photo: Banquet Guests at Head Table 1 in rear (l. to r.) Melvin R. Trosch, Honorary President, B.M.P.A. and President, Maryland News Company; Mrs. Trosch; Mrs. Joseph U. Dorsch; Joseph U. Dorsch, President, B.M.P.A. 1972; Mrs. Paul Freiman; Paul Freiman, President, B.M.P.A. 1973; Mrs. Melvin N. Rubin; Melvin N. Rubin, Banquet Chairman; Ralph Engel, Director, National Pharmacy Insurance Council; Dr. Torrey C. Brown, Delegate, Baltimore City, 2nd District; Mrs. Brown; Nathan I. Gruz, Executive Director, B.M.P.A. & M.Ph.A.; Mrs. Gruz;

Mrs. Charles E. Spigelmire; Charles E. Spigelmire, Banquet Marshall, Treasurer, B.M.P.A.

Head Table 2, front (l. to r.) Louis M. Rochman, Mrs. Louis M. Rochman, President, L.A.M.P.A.; Mrs. Charles H. Tregoe; Charles H. Tregoe, Chief, Division of Drug Control, State of Maryland; Mrs. Bernard B. Lachman; Bernard B. Lachman, President, M.Ph.A.; Mrs. Joseph S. Kaufman; Joseph S. Kaufman, Legal Counsel to B.M.P.A. & M.Ph.A.; Mrs. Ralph F. Shangraw; Dr. Ralph F. Shangraw, Chairman, Department of Pharmacy and Professor, University of Maryland; Mrs. John C. Matheny; John C. Matheny, President, T.A.M.P.A.



Photos by Paramount Photo Service

Bottom Photo: Officers and Executive Committee, Baltimore Metropolitan Pharmaceutical Association (l. to r.) Milton Sappe; Nathan I. Gruz, Executive Director; Barry Levin; Melvin R. Trosch, Honorary President; Donald Kirson; Joseph U. Dorsch, Chairman, Executive Committee; Stanley J. Yaffe; Paul Freiman, President; Ronald A. Lubman, Vice

President; Melvin N. Rubin, President Elect; Henry G. Seidman, Vice President; Charles E. Spigelmire, Treasurer; John E. Padousis, Vice President; and Gerald Freedenberg. Not present were Mark Levi, Ralph T. Quarles, and Bernard White.



—Photo by Paramount Photo Service

Upper left: Paul Freiman, Incoming President, makes presentation to Past President Joseph U. Dorsch. Upper right: Paul Freiman receives President's gavel from Installation Officer, Charles E. Spigelmire. Lower left: Melvin R. Trosch receives Honorary President's Plaque from Nathan I. Gruz,

Executive Director, B.M.P.A. and M.Ph.A. Center: Hon. Torrey C. Brown, M.D., Banquet Speaker. Lower right: Melvin N. Rubin, Toastmaster and Banquet Chairman, President Elect, B.M.P.A.

Baltimore Metropolitan Pharmaceutical Association

The Fifty-Seventh Annual Installation Banquet of the Baltimore Metropolitan Pharmaceutical Association was held on January 28 at the Blue Crest North in Pikesville. Many pharmacists and friends of pharmacy were in attendance at a very enjoyable affair. After cocktails and delicious hors d'oeuvres, guests entered the banquet hall where roast caponette imperial was the evening's entree.

The Call to Order was given by President Joseph U. Dorsch. Rabbi Seymour Essrog of the Beth Israel Congregation, Baltimore, then gave the invocation. This was followed by the singing of the Star-Spangled Banner with Nancy Lubman accompanying at the piano. Toastmaster

and Banquet Chairman Melvin N. Rubin introduced the banquet speaker, Dr. Torrey C. Brown, Delegate, 2nd District, Baltimore City.

After Dr. Brown's address, Charles E. Spigelmire, Banquet Marshall and Installation Officer, proceeded with the installation ceremony. After the current officers were discharged from office and the new officers installed, President Paul Freiman presented his remarks. Joseph U. Dorsch then received the Past President's Award from President Freiman. This was followed by the presentation to Honorary President Melvin R. Trosch by Nathan I. Gruz, Executive Director, B.M.P.A. and M.Ph.A. Mr. Trosch is President of the Maryland News Company. Rabbi Essrog then delivered the Benediction. Afterwards, there was dancing to the Morgan Baer Orchestra featuring Buddy Aaron.

ANNOUNCING:

First Annual Symposium on Pharmacology and Therapeutics

1973 Topic: *Drug Interactions — Mechanisms and Clinical Significance*

May 1, 1973

This symposium is presented by the University of Maryland School of Pharmacy fourth year professional class under the direction of the faculty of the Department of Pharmacology and Toxicology. Students will present papers on the mechanism and clinical significance of both well-known and potential drug interactions with an opportunity for discussion following each paper.

Pharmacists may receive Continuing Education credit at the rate of one credit for each two hours in attendance. The Maryland Pharmaceutical Association will be handling arrangements and registration for pharmacists as well as publishing the symposium program and abstracts. Further details including a program will appear in a future issue of *The Maryland Pharmacist*.

Order Your Tickets Today . . .

ALUMNI ASSOCIATION MARCH DINNER MEETING

Wednesday, March 28, 1973

Cash bar 6:00 p.m.

Dinner 7:00 p.m.

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GUEST SPEAKER—Dr. Louis L. Kaplan, Chairman,
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ALUMNI ASSOCIATION, UNIVERSITY OF
MARYLAND, SCHOOL OF PHARMACY

Dr. Louis L. Kaplan Speaker March Alumni Meeting

Dr. Louis L. Kaplan will be the guest speaker at the March Dinner Meeting of the University of Maryland's School of Pharmacy Alumni Association. The meeting will be held March 28 at the Valley Country Club in Towson.

Dr. Kaplan, a member of the University of Maryland Board of Regents since 1952, was elected its chairman in 1970. From 1930 to 1970, he served as President of the Baltimore Hebrew College and Executive Director of the Board of Jewish Education of Baltimore. He has been designated as President Emeritus. He is a member of the Board of Governors of The Dropsie University in Philadelphia, B'nai B'rith Commission on Adult Education and vice-chairman of the American Association for Jewish Education.

Dr. Kaplan has also distinguished himself in the literary field. He is the author of two books, "Justice, Not Charity" and "A New Approach to the Teaching of the Torah." He has edited many Hebrew texts and readers and presently serves as a member of the Publication Board of the Jewish Publication Society of America. He is chairman of the editorial committee of *Jewish Heritage*.

The Associated Jewish Charities and Welfare Fund has established the Louis L. Kaplan Professorship of Jewish Historical Studies at the University of Maryland, College Park. In 1946, Dr. Kaplan was awarded the King Christian X Liberation Medal by the King of Denmark, in appreciation of his leadership in raising a fund for the relief of Danish Jews who had escaped to Sweden.

Dr. Kaplan's educational background ranges from a B.A., Columbia University in 1922 to a D.H.L. from the Jewish Theological Seminary of America in 1970. He received his Ph.D. in 1927 from The Dropsie College and a D.H.L. in 1958 from Hebrew Union College-Jewish Institute of Religion. He also attended the American School of Oriental Research and the Institute of Jewish Studies of the Hebrew University, both in Jerusalem.

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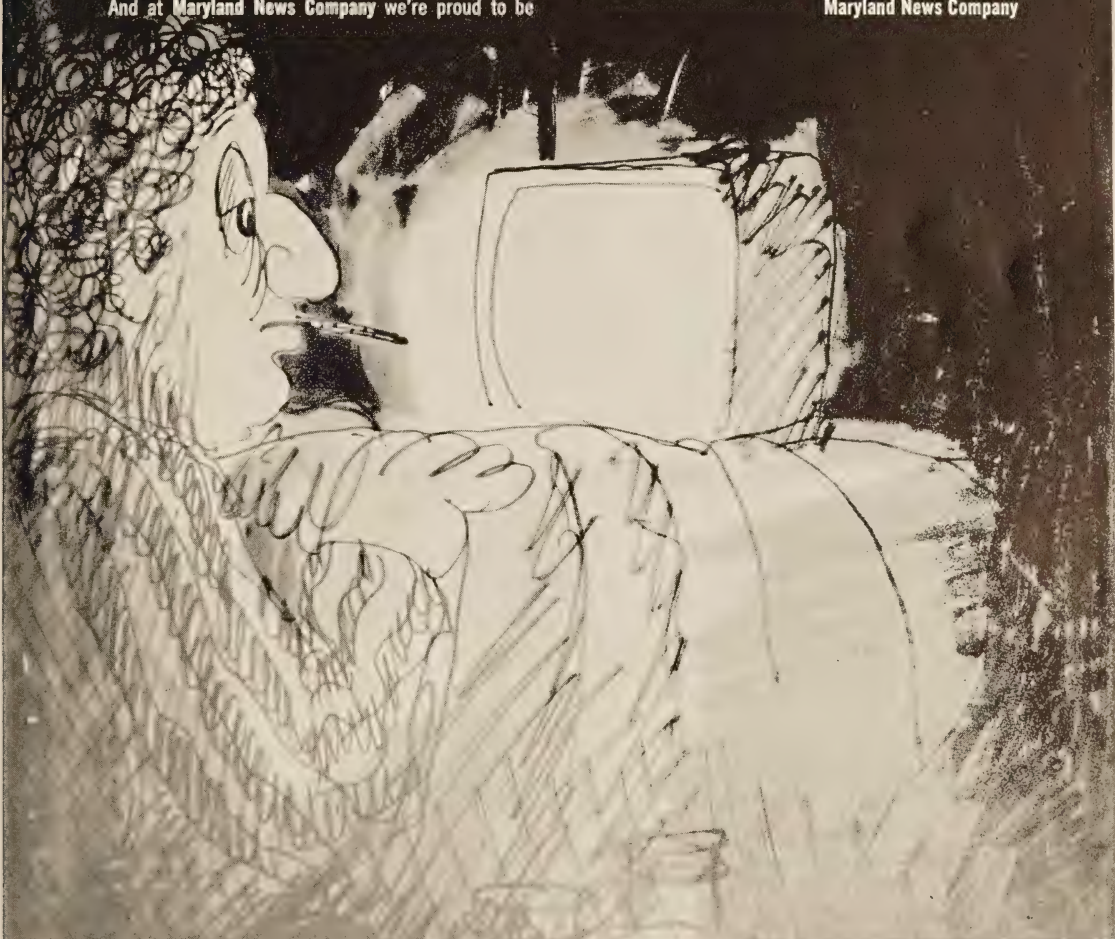
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Insulin Available in 100 Units per cc Strength

Eli Lilly and Company has announced the availability of U-100 insulin in six different forms. The six products—Regular, NPH, Protamine Zinc, Lente, Semilente, and Ultralente insulin are now supplied in new uniform, cylindrical U-100 vials with orange caps and black-and-white labels.

It is hoped that over a period of years the majority of insulin dependent diabetics will be using U-100 insulin preparations and that U-40 and U-80 concentrations will gradually be phased out.

Three special U-100 syringes are also being made available by the syringe manufacturers. The three U-100 syringes include a 1-cc (100-unit) disposable syringe, calibrated so that each mark represents 2 units; a 1-cc (100-unit) reusable glass syringe, calibrated in the same manner; and a 0.35-cc (35-unit) reusable glass syringe (to handle smaller doses) calibrated to represent single units.

The estimated resident population of Baltimore City as of July 1, 1972 is 881,000 persons with 446,000 white residents and 435,000 nonwhite residents. This represents a decline of 16,000 persons when compared with the July 1, 1971 estimated population of 897,000 persons.



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Obituaries

Lyttleton Sadler Green

Lyttleton Sadler Green, 73, former member of the Maryland Pharmaceutical Association and former member of the Harford County Liquor Board, died suddenly on January 11 at Harford Memorial Hospital.

Philip Sowbel

Philip Sowbel, 73, former member of the Maryland Pharmaceutical Association and father of pharmacist Irving Sowbel, died on January 19.

(Continued from Page 18)

Pharmaciens Catholique (International Federation of Catholic Pharmacists) and has been instrumental in the success of F.I.P.C. Congresses held in Montreal in 1969 and in Dublin, Ireland, in 1971. She has published articles written in both English and German in the *Albertus Magnus Blaetter* (Germany) and in the *Catholic Pharmacist* (U.S.A.).

Miss Heyer has presented numerous talks before student groups on Pharmacy as a career and on drug abuse. She is a member of the American Pharmaceutical Associ-

ation (Life Member), American Society of Hospital Pharmacists, American Board of Diplomates in Pharmacy, Federation Internationale Pharmaceutique, American Institute of the History of Pharmacy, Maryland Society of Hospital Pharmacists, Rho Chi, Phi Kappa Phi, and Lambda Kappa Sigma, Epsilon Alumnae Chapter.

Roche Initiates Inventory Update Program

A special program to help pharmacists remove discontinued items from their inventories has been initiated by Roche Laboratories. The company is asking all pharmacists to check their inventories for 23 products (94 line items) which previously have been designated as discontinued.

Pharmacists are to indicate on a form the number of packages of each item on hand, calculate the return values and return the items, along with the completed forms, to Roche Laboratories. After the returned items are processed and checked, the pharmacist will receive a check for the return value (wholesale cost plus 15 per cent), postage and handling charges. Reimbursement for partial packages will be prorated to the nearest quarter package.

This special program, for a limited period of time, ends April 30, 1973, and in no way alters Roche Laboratories' established return goods policy.

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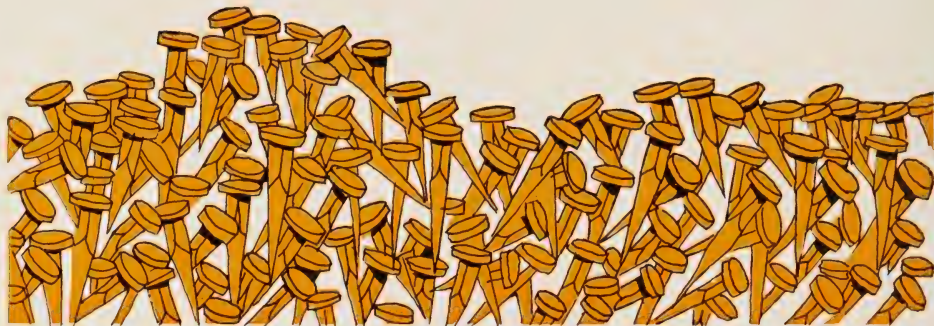


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the maryland pharmacist

FEBRUARY

1973

Volume 49

Number 2

Editorial—Don't Sell Drugs!

*First Annual Symposium on Pharmacology
and Therapeutics—May 1*

The Foundation: A Concept To Build On
by Albert I. Wertheimer

Wage and Hour Laws Affecting Pharmacies

MPhA Spring Regional Meeting and
House of Delegates Session

April 26, 1973

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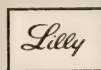
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NATHAN I. GRUZ, *Editor*
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HERMAN J. BLOOM, *Photographer*

650 WEST LOMBARD STREET
BALTIMORE, MARYLAND 21201
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VOLUME 49

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Editorial . . .

DON'T SELL DRUGS!

Today more than ever, people are price-conscious in all their purchases and this is especially true when it comes to prescriptions.

Unfortunately the public, to a great extent, thinks in terms of *buying a prescription* or "*drugs*," rather than of *paying for pharmaceutical services*.

What should a patron of a pharmacy conclude when in seeking to get a prescription filled, he is met by an ordinary drugstore clerk who receives the prescription order form and passes it to the pharmacist? When the required medication is duly packaged, the clerk hands the package back to the patron.

Too often today there is little or no patient contact. Too often there is no pharmacist-patient relationship where the pharmacist determines whether the patient has some understanding of how the medication is to be used. No personal relationship can be built without frequent contact which conveys the pharmacist's genuine interest in the patient's predicament.

Cut-throat pricing practices, use of "loss leaders," discount image, gimmicks and huckster advertising techniques become the keynotes for mass merchandising operators using and misusing the "prescription department" to sell everything under the sun.

Those who look for diversification in health-related goods and services, who emphasize professional concern (patient medication records), who provide personalized service, who maintain pharmacist-patient relationships, and who use an equitable, yet realistic, fee for service, have demonstrated the ability to survive. Certainly only a few giants can survive a game plan where the participants are trying to determine who set the lowest prices. For the majority, identification with professional competence and service together with reasonable fees and prices presents solid prospects in the months and years just ahead.

Don't sell drugs — provide pharmaceutical services!

—NATHAN I. GRUZ

Sustaining Members Maryland Pharmaceutical Association

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Six From Pharmacy Listed On 16-Member OPPV Review Committee

The 16-member Optometry, Pharmacy, Podiatry and Veterinary Medicine Education Review Committee consists of six members representing Pharmacy, four from Veterinary Medicine, three from Optometry and three from Podiatry.

The six pharmacy members are: Mrs. Mary L. T. Andersen, pharmacist, Wilmington, Delaware; Dr. Ann L. Czerwinski, Professor of Pharmacology, Creighton University, Omaha; Dr. Robert D. Gibson, Director, Pharmaceutical Technology Laboratory, University of California, San Francisco; Dr. George P. Hager, Dean, School of Pharmacy, University of North Carolina, Chapel Hill; Dr. William J. Kinnard, Jr., Dean, School of Pharmacy, University of Maryland, Baltimore; and Dr. August P. Lemberger, Dean, College of Pharmacy, University of Illinois, Chicago.

PHARMACY CALENDAR

April 26 (Thursday) — Spring Regional Meeting, Maryland Pharmaceutical Association, Friendship International Hotel, Friendship Airport.

May 10 (Thursday) — Maryland Society of Hospital Pharmacists meeting at St. Joseph's Hospital, Towson.

May 15 - 21—Maryland Pharmaceutical Association. Fiesta in Spain. Convention and tour.

June 15 - 17—Eighth Annual Hospital Pharmacy Seminar—Maryland Society of Hospital Pharmacists, Diplomat Motel, Ocean City, Maryland.

June 29 - July 1—91st Annual Convention, Maryland Pharmaceutical Association. Hunt Valley Inn, near Baltimore.

July 21-27—American Pharmaceutical Association Annual Meeting, Boston, Massachusetts.

December 9 - 13—American Society of Hospital Pharmacists Midyear Clinical Meeting, New Orleans, Louisiana.

DID YOU HIRE A NEW PHARMACIST LATELY? . . . OPEN A NEW BRANCH? . . . GET ELECTED TO OFFICE IN YOUR SERVICE CLUB OR SOCIAL ORGANIZATION? . . . BECOME ASSOCIATED WITH ANOTHER PHARMACY?

WE WOULD LIKE TO KNOW—AND SO WOULD OUR READERS. WHY NOT DROP US A LINE AT THE MPhA OFFICE TODAY.

Announcing a program to facilitate the return of previously discontinued Roche pharmaceutical products.

Current inventories are not always easy to maintain. At Roche, we understand your difficulties and want to do all we can to help you keep your stock up-to-date.

The Roche Retrieval Program is part of our effort to facilitate the return of previously discontinued Roche items. It offers you an opportunity to convert these no longer usable products into cash.

An Explanatory Mailing, scheduled for early February, will include a letter describing the program, a 6-part return goods form listing the approximately 95 items discontinued over the years, and a BRC for pharmacies which have no returnable merchandise.

All You Need Do is check your inventory for the listed items, calculate their return value and return them to Roche. If you have none of the items, please indicate this on the BRC and send it to Roche.

You Will Receive A Check for the value of items which you return, plus your postage costs.

Our Established Return Goods Policy is in no way altered by this special campaign. Only those products specified in the returned goods form may be returned under this program; other unsalable Roche items must be handled separately and in the customary manner.

**The Roche Retrieval Program will
end on April 30, 1973—so don't delay
in returning your discontinued items.**



ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

MPhA In Action

Board of Trustees Meeting

NATHAN I. GRUZ, *Executive Director*

January 11, 1973

The following is a summary of actions taken at the January 11, 1973 meeting of the Board of Trustees:

- Noted receipt of letter from APhA regarding FDA regulations on packaging for aspirin-containing products.
- Noted receipt of letter from NARD regarding annual conference on national legislation and public affairs in Washington, D.C., April 11 and 12, 1973.
- Received President's report commenting on memorandum by Judge Carter on prescription price advertising and the need to observe the results of the drug product selection bill. The President announced that Vice President Mary W. Connelly would head a committee to work with the Maryland Society of Hospital Pharmacists on closer relations and possible affiliation.
- Approved Treasurer's report.
- The Executive Director reported on attendance at meeting on legislation; conferences with other health professional associations; third party payment plans; Pharmaceutical Services Foundation; HEW third-party task force; NPIC Annual Meeting; meetings with Dean Kinnard, especially on continuing education; BMDA Annual Meeting; BMDA conferences; Maryland Board of Pharmacy; Planned Parenthood, work on a survey and training institute; National Coordinating Council on Drug Abuse Education as representative of the National Council of State Pharmaceutical Association Executives; and Tri-State Hospital Association.
- Also attended meetings of Maryland Society of Association Executives; Prince Georges-Montgomery County Legislative delegation affair; addressed the Maryland Society of Hospital Pharmacists and the Perry Hall Optimists Club; negotiated with administrators for Local 355 plan to provide for freedom of choice of pharmacy and was interviewed by the Sunpapers regarding the effect of safety prescription drug containers. Also reported on the progress of a Blue Cross/Blue Shield plan for members.
- Received Convention Committee report noting Hunt Valley Inn had been selected as site for annual convention on June 29, 30 and July 1. Work is proceeding on a regional meeting for April 26.
- Received Legislative Committee report noting bills had been introduced in legislature to repeal the advertising law and the Fair Trade law and to require pharmacists to place general use for drug on the prescription label.
- Approved Membership Committee report.
- Approved Professional Relations Committee report describing activities including an exhibit at the Annual Meeting of the State Medical Society and a seminar on family planning with Planned Parenthood.

- Received Prescription Insurance Plans Committee report noting extensive activities. Topics included utilization review project for state Medicaid by the Pharmaceutical Services Foundation (Melvin Rubin is co-chairman of this PSF committee), and State directive on acquisition cost for Medicaid. A conference was held with Assistant Secretary of Health Administration Rosenbaum. Agenda included temporary cards and prescriptions for OTC drugs. The state promised to clear up all 1970 and 1971 invoices by the end of March and to have six-month cleanups where rejects would be reviewed every six months for payment. Temporary cards are to be eliminated within a year. It was pointed out that because of the OTC prescription policy, the actual fee for prescriptions was possibly as low as \$1.55 for many pharmacies.
- Mr. Gruz reported on attendance at Board of Pharmacy meeting. The agenda included cases involving violation of the prescription advertising law, suspension of a pharmacist's license, use of supportive personnel, state legislation and reciprocity.
- Approved contribution to the Student Committee of Drug Abuse Education.
- Approved 1973 budget calling for receipts and expenditures of \$54,200.
- Approved appointment of Bernard Lachman, Anthony Padussis and Nathan I. Gruz as delegates to 1973 APhA Annual Meeting.
- Noted that Executive Director will attend NARD Legislative Conference in connection with meeting of NCSPEA.
- Approved subsidy toward expenses of Dr. Sheila West as MPhA representative at NARD Venereal Disease Conference in Houston.
- Noted announcement by House of Delegates Speaker Henry G. Seidman that the Constitution and Bylaws and Nominating Committees had been activated.
- Noted announcement by President Lachman that a committee on consumer relations would be established with a service to be announced to the public.

New Members

The following is a list of the new members approved at the January 11, 1973 meeting of the Board of Trustees of the Maryland Pharmaceutical Association:

Joseph Adir, Owings Mills, University of Maryland,
School of Pharmacy
Donald Aronson, Annapolis
Barry Bloom, Randallstown
Dolores Duke, Silver Spring, Sick Children's Hospital
Stephany Knower, Baltimore, USPHS Hospital



Legend drugs in their own time

First Annual Symposium on Pharmacology and Therapeutics

**Place: Holiday Inn, Downtown Baltimore,
Lombard and Howard Streets**

This symposium is presented by the University of Maryland School of Pharmacy fourth year professional class under the direction of the faculty of the Department of Pharmacology and Toxicology. Students will present papers on the mechanism and clinical significance of both well-known and potential drug interactions with an opportunity for discussion following each paper.

Pharmacists may receive Continuing Education credit at the rate of one credit for each two hours in attendance. The Maryland Pharmaceutical Association will be handling arrangements and registration for pharmacists as well as publishing the abstracts.

**FEE: Registration, including luncheon with
guest speaker — \$6.00**

Luncheon Guest Speaker: W. Leigh Thompson,
M.D., Ph.D., Director of the Medical Intensive Care Unit,
Johns Hopkins Hospital.

Name

Address

Enclosed is a check for reservations.

☐ Symposium & lunch ☐ Symposium only

Program Of Papers:

TUESDAY MORNING, May 1, 1973

Room 201, Allied Health Professions Building,
32 S. Greene Street

- 8:45 1 Alcohol and Monoamine Oxidase Inhibitors.
David C. Curry
- 9:00 2 Digitalis Glycosides and Reserpine (Serpasil).
William V. Zappa
- 9:15 3 Monoamine Oxidase Inhibitors and High Tyra-
mine Diet. **Barry L. Louria**
- 9:30 4 Bishydroxycoumarin (Dicoumarol) and Spiro-
nolactone (Aldactone). **Dennis L. Meyers**
- 9:45 5 Propranolol (Inderal) and Oral Hypoglycemics
Harold D. Harrison
- 10:00 6 Guanethidine (Ismelin) and Amitriptyline
(Elavil). **Dorothy H. Humphreys**
- 10:15 7 Disulfiram (Antabuse) and Diphenylhydantoin
(Dilantin). **Leslie A. Benson**
- 10:30 8 Probenecid (Benemid) and the Penicillins. **Wayne
A. Borkoski**
- 10:45 9 Neomycin and Neuromuscular Blocking Drugs.
Elwood L. Fletcher
- 11:00 10 Vitamin B-6 (Pyridoxine) and L-Dopa (Levo-
dopa). **Carroll G. Rusk, Jr.**
- 11:15 11 Diazepam (Valium) and Barbiturates. **Francis
Vocci**

Room 217, Allied Health Professions Building,
32 S. Greene Street

- 8:45 12 Tolbutamide (Orinase) and Salicylates. **Philip M.
Perry**
- 9:00 13 Bishydroxycoumarin (Dicoumarol) and Tolbuta-
mide (Orinase). **Florence F. Kwong**

- 9:15 14 Reserpine (Serpasil) and Anticonvulsants.
Chrisoula J. Economides
- 9:30 15 Monoamine Oxidase Inhibitors and Narcotic
Analgesics. **Nikola L. Kuhn**
- 9:45 16 Alcohol and Tricyclic Antidepressants. **Barry L.
Keeler**
- 10:00 17 Bishydroxycoumarin (Dicoumarol) and Pheno-
barbital. **Robert J. Martin**
- 10:15 18 Alcohol and Insulin. **Frances H. Cohen**
- 10:30 19 Anticholinergic Drugs and Phenothiazine Tran-
quilizers. **Kim P. Fisher**
- 10:45 20 Phenobarbital and Griseofulvin. **William R.
Addington, Jr.**
- 11:00 21 Atropine and Meperidine (Demerol). **Claude W.
Nogay**
- 11:15 22 Prednisone (Meticorten) and Iproniazid (Marsi-
lid). **Harry J. Williams**

Health Sciences Library Auditorium

- 8:45 23 Tetracyclines and Calcium. **Paul L. Fader**
- 9:00 24 Diphenhydramine (Benadryl) and Anticholinergic
Drugs. **Benjamin E. Carter**
- 9:15 25 Diphenylhydantoin (Dilantin) and Vitamin D
Metabolism. **Bonnie L. Pitt**
- 9:30 26 Guanethidine (Ismelin) and L-Dopa (Levodopa).
Milton Proudfoot
- 9:45 27 Acetohexamide (Dymelor) and Phenylbutazone
(Butazolidin). **Thomas S. Sheler**
- 10:00 28 Isoproterenol (Isuprel) and Digitalis Glycosides.
Stanley J. Stefanoski
- 10:15 29 Warfarin (Coumadin) and Chloral Hydrate (Noc-
tec). **Stanton G. Ader**
- 10:30 30 Monoamine Oxidase Inhibitors and Amphet-
amines. **Harry N. Cook**
- 10:45 31 Anticoagulant Drugs and Thyroid Replacement
Therapy. **Michael Schneyer**
- 11:00 32 Alcohol and Disulfiram (Antabuse). **Eugene R.
Louden**
- 11:15 33 Bishydroxycoumarin (Dicoumarol) and Indo-
methacin (Indocin). **Larry K. Westfall**

LUNCHEON — 11:45-1:15 Howard and Lombard Streets,
Holiday Inn (Grand Ballroom). Guest speaker
Dr. W. Leigh Thompson

TUESDAY AFTERNOON, May 1, 1973

Room 201, Allied Health Professions Building, 32 S. Greene
Street

- 1:30 34 Alcohol and Barbiturates. **Paul J. Crist**
- 1:45 35 Bishydroxycoumarin (Dicoumarol) and Clofibrate
(Atromid-s). **Leonard Patras**
- 2:00 36 Monoamine Oxidase Inhibitors and Methyl-dopa
(Aldomet). **Louisa Chen**
- 2:15 37 Digitalis Glycosides and Thiazide Diuretics. **Vir-
ginia T. Kreul**
- 2:30 38 Oral Contraceptives and Oral Hypoglycemics.
Pamela K. Lindsay
- 2:45 39 Guanethidine (Ismelin) and Phenylephrine (Neo-
Synephrine). **David Schlein**
- 3:00 40 Isoniazid (Nydrazid) and Diphenylhydantoin (Di-
lantin). **Walter T. Dolan**
- 3:15 41 Mercaptopurine (Purinethol) and Allopurinol
(Zyloprim). **Linda F. Wohl**
- 3:30 42 Lincomycin (Lincocin) and Kaolin. **Janet M.
Jones**
- 3:45 43 Methyl-dopa (Aldomet) and Amitriptyline (Ela-
vil). **Louise F. Quan**
- 4:00 44 Amitriptyline (Elavil) and Chlordiazepoxide
(Librium). **Jerry L. Wilhelm**
- 4:15 45 Antihistamines and Antihypertensives. **David L.
Bennion**

(Continued on Page 16)

How do you know the products you dispense meet the standards?

Comparisons of "Chemically Equivalent" Products

Variations in 20 lots of
Theophylline, Ephedrine Hydro-
chloride and Phenobarbital tablets
manufactured by thirteen firms¹

45%
(9 out of 20
lots)

% of lots not
meeting NF
standards for
labeled
content

65%
(13 out of 20
lots)

% of lots not
meeting NF
dissolution
standards

Warner/Chilcote

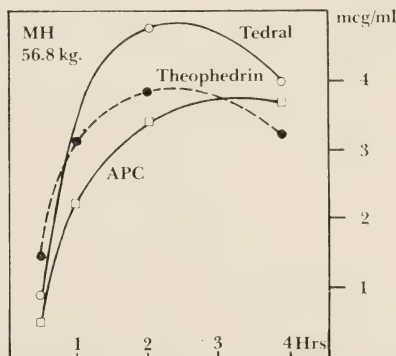
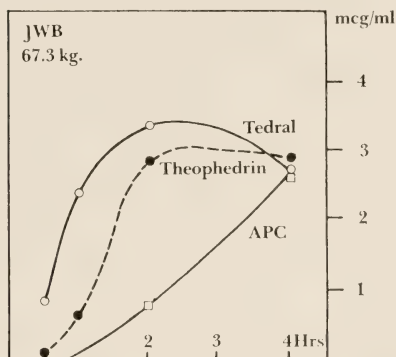
Division,
Warner-Lambert Company
Morris Plains, N.J.
07950



1. Lach, J. L., Chin, T. and Parrott, E. L.:
Variations in Theophylline, Ephedrine
Hydrochloride and Phenobarbital Tablets
Manufactured by Thirteen Firms, to be
published. 2. Bettis, J. W., Lach, J. L. and
Hood, F.: Effect of Complexation Upon the
Biologic Availability of Theophylline, to be
published.

Blood Level Comparison: Tedral* vs Two Generic T-E-P's

Bettis and associates² found higher
blood levels of theophylline from
Tedral than from two formulary
alternates in 6 of 9 subjects



They concluded that the differences between Tedral and the two alternates could be due to differences in the extent of interaction between theophylline and phenobarbital during manufacture. (The USP and NF do not specify methods of manufacture to be used for T-E-P drugs.) As a result of this study, the use of substitutes for Tedral was discontinued at this university hospital.

*Each tablet contains 130 mg theophylline, 24 mg ephedrine HCl, and 8 mg phenobarbital.

Warner/Chilcote products meet the standards — and then some.

Maryland Board of Pharmacy News

Pharmacy Changes

The following are the pharmacy changes for the month of February:

New Pharmacies

Alpert's Pharmacy, Charles M. Alpert, President; 801 Park Avenue, Baltimore, Maryland 21201.

Thrifty-Wise, Arthur K. Solomon, President; 9632 Belair Road, Baltimore, Maryland 21236.

Thrifty-Wise, Arthur K. Solomon, President; 1737-43 Chesaco Avenue, Baltimore, Maryland 21237.

Drug Fair No. 157, Milton L. Elsbeg, President; 1404 Market Street, Pocomoke City, Maryland 21851.

No Longer Operating As Pharmacies

Northview Pharmacy, Inc., Stella Vodenos, President; 9632 Belair Road, Baltimore, Maryland 21236.

Changes of Ownership, Address

Halethorpe Pharmacy, Latimer Alexander, (Change of ownership); 1307 Francis Avenue, Baltimore, Maryland 21227.

I. J. Heneson Pharmacy, Inc., Irving J. Heneson, President; (Change of ownership), Charles and 25th Street, Baltimore, Maryland 21218.

Hospital Center Pharmacy, Inc., Louis R. Kern, Jr., President; (Change of ownership and name), 601 South Union Avenue, Havre de Grace, Maryland 21076.

Assignment of Internal Code Number by Hospitals to Unlicensed Interns and Residents Not Applicable to Schedule II Controlled Drugs

Pharmacists are reminded that prescriptions written for Schedule II Controlled Drugs by unlicensed interns and residents using internally assigned control numbers are not valid. Code numbers are assigned by hospitals or institutions to unlicensed interns and residents. The code number consists of numbers, letters, or a combination thereof which are a suffix to the institution's BNDD registration number, preceded by a hyphen (e.g., APO123456-10 or APO123456-A12). (See *Maryland Pharmacist*, August, 1971, page 11)

According to regulations of the Maryland State Board of Medical Examiners approved by the Secretary of Health and Mental Hygiene of Maryland on November 9, 1971, resident physicians or interns shall:

"in no way prescribe or otherwise provide any substance listed on the Controlled Dangerous Substances Act, Schedule Number Two to any patient for use or consumption off the premises of the hospital employing him in such a capacity."

University of Maryland School of Pharmacy

DR. DEAN E. LEAVITT, Associate Professor and Chairman, Department of Pharmacy Administration, has been named to a consultant advisory panel charged with helping the National Pharmacy Insurance Council develop a uniform cost accounting system that will provide data on the costs of dispensing prescribed drugs and form a basis for equitable prices.

DR. GARY BUTERBAUGH, Assistant Professor of Pharmacology and Toxicology, has been awarded a \$10,000 grant to research "Brain Monoamines, Inhibitory Mechanisms, and Seizure Susceptibility." The grant, made through the Epilepsy Foundation of America, will finance a one-year study of brain monoamines (chemical transmitters within the central nervous system) and the effect of certain convulsant drugs on the levels of monoamines in the brain.

Dean WILLIAM J. KINNARD, Jr., has been appointed to a four-year term on the Optometry, Pharmacy, Podiatry and Veterinary Medicine Education Review Committee, a public advisory group to the National Institutes of Health. The committee, which meets four times a year, is charged with reviewing construction grant applications, special project grant applications, and other grant applications submitted under the provisions of the Comprehensive Health Manpower Training Act of 1971, in accordance with guidelines established by the National Advisory Council on Health Professions Education.

DR. PETER P. LAMY, Director of Institutional Pharmacy Programs and Professor of Pharmacy, has been invited to speak at the Seventh Annual International Clinical Study Tour of the American Society of Hospital Pharmacists. Programs will be held in Leningrad, Moscow and Munich October 7-22, 1973. Dr. Lamy will participate in a professional practice clinic panel in Moscow on October 15 and will deliver a talk on "Innovative Hospital Pharmacy Services" in Munich on October 19.

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Maryland Pharmaceutical Association

**Spring Regional Meeting and
House of Delegates Session**

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Thursday, April 26, 1973

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The Foundation: A Concept to Build Upon

Albert I. Wertheimer, Ph.D.

Presently working with the Pharmacy Related Studies Branch at the National Center for Health Services, Research & Development Department of Health, Education and Welfare.

Formerly Assistant Professor at State University of New York at Buffalo.

Presented at University of Maryland School of Pharmacy, Continuing Education program entitled "Your Practice and HMO's — PHARMACY'S FUTURE IS NOW," November 12, 1972.

Let us try to assemble a picture of the history, development, status and characteristics of the foundation. According to *Medical World News*, "only two years ago, there were perhaps no more than a half-dozen foundations for medical care (FMC's), all on the west coast, home of the movement's progenitor, the San Joaquin Foundation for Medical Care." Boyd Thompson, executive director of the American Association of Foundations for Medical Care (AAFMC) counts 112 foundations in or near operation today. These FMC's, all sponsored by state or county medical societies, have engaged the active participation of over 87,000 physicians. Are FMC's simply a conservative bid to escape outside control of medical practice or to thwart liberal reform of the health care delivery system, as suspected by some or are foundations aimed at salvaging and bolstering the private sector which needs aid?

Since there has been very little written about pharmacy foundations, we shall examine the medical foundation literature and translate the word medical to pharmacy where appropriate. A foundation appears to be an organizational device that: enlists practitioners as private health care contractors; promotes a continuance of fee-for-service; offers a measure of group practice benefits; and insures colleague review. In a foundation arrangement, the practitioner is paid a fee-for-service by the foundation.

The San Joaquin Foundation for Medical Care was established in 1954 to forestall a planned Kaiser facility move into Stockton. San Joaquin provides care today for 80,000 persons. It handles about 320,000 doctor claims and 436,000 pharmacy claims annually.

Dr. Andrew Fleck, New York City's Deputy Health Commissioner has stated: "It has become increasingly clear that ideally the consumer should have available a system that discourages the provision of inappropriate care by placing the physician at risk as a co-insurer, and guards against faulty utilization by requiring him to accept professional regulation and economic discipline by his peers".² Foundations for medical care seem to be all things to all men. In their variety, they defy tight definition, as their charters permit them to develop in whatever direction their members choose.

In September, 1971, *Medical Economics*³ advised physicians about the foundation in an article entitled: "There's A Medical Foundation in Your Future."

How Most Medical-care Foundations Work

MEDICAL SOCIETY—A state or county medical society establishes a separate nonprofit foundation to care for patients who acquire health insurance—usually through group policies—that meet foundation-prescribed standards of coverage.

DOCTORS—Every physician who belongs to the medical society or is eligible to join it may become a member of the foundation. In some he pays annual dues. The key condition for membership: The doctor must agree to accept reimbursement from foundation patients' insurers not exceeding specified maximums for each type of service.

INSURERS — Cooperating health insurance carriers write policies giving foundation patients the prescribed broad scope of benefits—with emphasis on office care and other low-cost options. In return the insurers get not only the agreed-upon fee ceilings but also policing of claims by the foundation.

FOUNDATION—The Foundation's biggest function is peer review. In most cases the insurers delegate to it the processing of all health insurance claims by or for foundation patients. Some foundations even have check-writing authority. A doctor who has a charge cut back or disallowed claim has the right to appeal to a foundation peer-review committee.

Essentially, foundation may be considered a form of a Health Maintenance Organization (HMO). We must keep in mind that HMO's and foundations are organizations that utilize a different type of financing of care than that prevalent with the fee-for-service payment to the solo or individual practitioner. HMO does not relate to the type of facility that actually provides the care, as is the case with the foundation. The organization and financing characteristics separate HMO's and foundations from our traditional experiences. Understanding this, we may go on and actually consider the foundation as a type of HMO. We can discern three types of HMO's categorized by the centralization of their structures. The first type—most tightly organized and centralized would be the one-stop health service center such as Kaiser, where all services are in-house. The second, or less rigidly organized scheme might use some HMO-owned facilities in conjunction with vendor services and subcontracted work. The third HMO model, one where only the fiscal services are centralized and where the health care is provided by independent contractors, members or others in diverse settings, is the foundation.

One of the most insightful works dealing with pharmacy foundations is an article by Finch⁴ which is must

reading for everyone. Finch reports that up to recently, pharmacists participating in group practices and prepaid health care plans, are employees, with very little voice in the overall delivery of their services. He wastes no words in telling us that: "the foundation concept can be adapted to the practice of pharmacy, and may be one way to preserve and integrate the independent practice of pharmacy into the medical care delivery system of tomorrow."

There can be no question of the fact that the success of a pharmacy foundation is dependent upon local review and control. The foundation forces the pharmacists in an area to establish standards for the delivery of pharmaceutical services. The local groups after adopting agreed upon standards or guidelines thereby create norms which must be adhered to by the foundation members as a necessity for maintaining membership, which is the basis for its value. Now the pharmacists have a yardstick to measure quality and an economic tool with which to insure adherence to quality standards.

Today, there are nine* pharmacy foundations operational or nearly operational according to Mr. Ralph Engel, the forward thinking Director of the National Pharmacy Insurance Council. All of these follow the NPIC's Guidelines for a Pharmacy Group Practice.⁵ Most of the existing plans call for pharmacy foundations to act as subcontractors to Medical Foundations for the pharmaceutical services component.

Engel described recently the nature of the NPIC Guidelines: "The guides are divided into four sections. The first deals with the form of a group practice, the basis of which is a corporate nonprofit pharmacy foundation. What is meant is that an unassembled group of practitioners retain their current practice in their current setting but unilaterally contract via the corporation to provide pharmaceutical services. The group practice is an autonomous corporation, with its own board of trustees."

Each pharmacy provider can apply for membership in the corporation and upon being accepted, may participate in all programs and activities offered.

It is important to note at this time that for the corporation to function properly, pharmacists in a given community must first relate to each other and form a corporation, and secondly, they must also relate to physicians and other prescribers in the area to establish an effective drug utilization review mechanism.

Steps to develop a Nonprofit Pharmacy Group Practice are outlined in the Guidelines and although there are some difficulties anticipated, none are insurmountable.

The applicable laws are generally discussed, as are the internal legal arrangements between the corporation and the participating pharmacies. Also included are the external legal arrangements, or agreements between the corporation and health maintenance organizations, medical group practice plans, unions and the like.

This system will place the responsibility for the administration and control of pharmaceutical service programs in the hands of the profession and provide them

with the mechanisms needed to contract with medical foundations, unions, group practice plans, trusts, and government agencies. It will allow pharmacy to participate in the emerging health care delivery system.

The pharmacy foundation is not to be confused with an HMO. It is not in itself a Health Maintenance Organization since it does not offer comprehensive health care. It can and must be considered as a necessary component of an HMO. In other words, the HMO will act as the general contractor of health care while the pharmacy foundation will be a subcontractor for pharmaceutical services.

The pharmacy foundation should serve both the consumer-patient interest as well as the profession's interest, with its objectives being five in number.

1. To provide comprehensive pharmaceutical services efficiently and economically;
2. To develop standards of practice in and for a geographic area;
3. To negotiate contracts for providing pharmaceutical services with medical foundations, unions, other group practice plans, trusts and government agencies;
4. To organize and operate peer review activities so that the corporation can objectively and effectively deal with irregularities; and
5. To establish a drug utilization review mechanism to study the frequency of use and cost of drugs from which patterns of prescribing, dispensing and patient use can be determined.

The corporation allows for the traditional free choice of pharmacy service. Further it offers the mechanism for either the fee-for-service, or fee-per-patient concept and control over utilization through peer review.

Particular attention should be paid to the reimbursement mechanism, since, it is likely that, pharmacy will be further challenged to prove that it can provide comprehensive pharmaceutical service efficiently and effectively in its present structure.

Essentially there are three potential methods of reimbursement. One could well be the 'fee-for-service' with which all are familiar. This approach is currently used by most third-party programs and could remain in effect in some future programs. A second method might be capitation, which is the periodic payment of a flat amount per enrollee or enrolled family, to cover all pharmaceutical service offered by the group.

The third potential methodology could be prospective reimbursement. Under this budgeting-in-advance method, a set amount is paid to the corporation, figured against the annual, anticipated total number of services to be provided by the corporation to the enrolled population. This method might work as follows: A pharmacy anticipates dispensing 5,000 prescriptions to the enrollees at an annually average operational cost of \$4 per prescriptions. That pharmacy's total annual payment would be \$20,000 for the year.

*California (3); New Mexico; Bergen Co., New Jersey; Denver, Colorado; Maryland; Virginia; Portland, Oregon.

The last two methods involve a factor presently alien to most health care providers, including pharmacists; namely, risk sharing. If utilization is less than anticipated, the provider gains an added profit. However, if utilization exceeds anticipated levels, the provider shares in the loss.

The functioning arm of a group practice prototype is what is termed the Pharmacy Service Review Organization (PSRO). It is their responsibility to develop basic standards and guidelines for pharmaceutical services pertinent to the geographic area served by the foundation and, further, to monitor these standards and guidelines. This group is also referred to as a PSEC (Pharmacy Service Evaluation Committee).

This committee should be composed of pharmacists, who, along with administrators and/or insurers, physicians, and consumers, review patterns of drug utilization in the program in which they participate.

The group will function in these general areas; pharmacy review, which includes claims review as well as drug utilization review. It will also act as a peer review mechanism, thus incorporating an educational function.

Finch expands his speculation regarding possibilities stating: "Once the foundation is functioning and a prepaid group is enrolled, the foundation, again through committees, should study methods of reducing cost and maintaining cost controls other than merely through utilization controls. This can be accomplished by statistical evaluation of operational costs, means of overhead reduction, pooling for purchasing drugs, offering prescription delivery services universally for all foundation members and other sound business management controls."

This then is the pharmacy foundation. Establishment and operation of the foundation is only the first step. Marketing it to FMC's and the consumer is another matter. Fortunately, the matter has received thorough attention in a publication entitled: "Marketing Pre-Paid Health Care Plans," distributed by the Health Services and Mental Health Administration.* In it six papers are presented by experts, dealing with marketing, enrollment strategy, foundation experiences and procedures.

In summary several points need to be repeated and/or stressed.

- The foundation is only one approach and must be attempted and evaluated even though it may not solve *all* existing problems.
- The problems surrounding foundations are formidable, but not necessarily insoluble.
- On-risk is a feature pharmacists must learn to accept, although risk can be reinsured (too costly), it should be partially assumed by the physicians who actually control the drug utilization in a program.
- If the independent, community practice is to survive and prosper, innovative schemes such as capitation

pricing, foundations, risk sharing and peer review must be accepted.

—We have the compass directions. If we do not locate and mesh with the overall health care delivery system, it is no one's fault, but our own.

References

1., "A Bid for Independence," *Medical World News*, 13, No. 39, 47-55, (October 20, 1972).
2. *Ibid*, *Medical World News*.
3. Eisenberg, Howard, "There's A Medical Foundation in Your Future," *Medical Economics*, September 27, 1971.
4. Finch, Dennis, "Opportunities For A Prepaid Pharmacy Foundation," *California Pharmacist*, 12-14, October, 1971.
5., National Pharmacy Insurance Council Guidelines For the Formation of a Prototype Pharmacy Group Practice, NPIC, Washington, 1971.
6. Engel, Ralph, "HMO's—A Professional Challenge," address before the National Council of State Pharmaceutical Association Executives Meeting, Chicago, October 1, 1972.
7. Finch, *op cit* p. 14.

First Annual Symposium

(Continued from Page 10)

Room 217, Allied Health Professions Building, 32 S. Greene Street

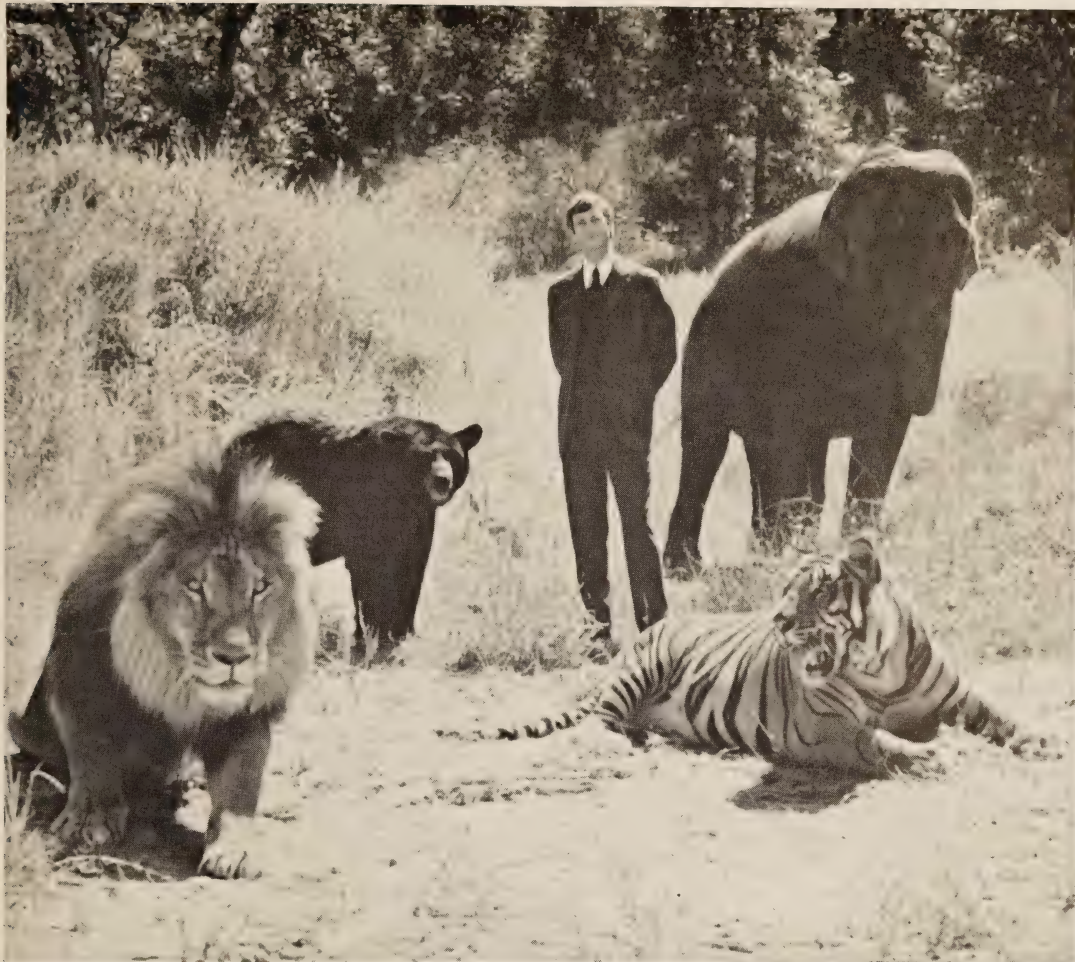
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|------|----|--|
| 1:30 | 46 | Antihypertensives and Thiazide Diuretics. Adrienne K. Watson |
| 1:45 | 47 | Propoxyphene (Darvon) and Orphenadrine (Norflex). John F. Bender |
| 2:00 | 48 | Tolbutamide (Orinase) and Chloramphenicol (Chloromycetin). Nagla A. Wahab |
| 2:15 | 49 | Bishydroxycoumarin (Dicoumarol) and Oral Contraceptives. Joseph L. Pollard |
| 2:30 | 50 | Alcohol and Nitroglycerin. Hal J. Weinstock |
| 2:45 | 51 | Monoamine Oxidase Inhibitors and Imipramine (Tofranil). Richard W. Pollhammer |
| 3:00 | 52 | Alcohol and Chloral Hydrate (Noctec). Peter Ritterstein |
| 3:15 | 53 | Monoamine Oxidase Inhibitors and Antihistamines. Joseph E. Parker |
| 3:30 | 54 | Phenobarbital and Diphenylhydantoin (Dilantin). Jay R. Newirth |
| 3:45 | 55 | Methylphenidate (Ritalin) and Anticonvulsant Drugs. Walter J. Hryszko |
| 4:00 | 56 | Heparin and Basic Drugs. Michael S. Luger |
| 4:15 | 57 | Probenecid (Benemid) and Salicylates. Robert P. Zepp |

Health Sciences Library Auditorium

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|------|----|---|
| 1:30 | 58 | Meperidine (Demerol) and Promazine (Sparine). Katherine A. Montalbano |
| 1:45 | 59 | Tricyclic Antidepressants and Hydrocortisone (Cortef). Robert R. Foreman |
| 2:00 | 60 | Cholestyramine (Questran) and Intestinal Absorption of Drugs. Russel A. Gobeille |
| 2:15 | 61 | Diphenylhydantoin (Dilantin) and Dexamethasone (Decadron). Thomas E. Donohue |
| 2:30 | 62 | Guanethidine (Ismelin) and Anorexics. Ralph A. Small |
| 2:45 | 63 | Digitalis Glycosides and Thyroid Replacement Therapy. Thomas S. Petr. |
| 3:00 | 64 | Bishydroxycoumarin (Dicoumarol) and Antibiotics. Marta M. Procinisky |
| 3:15 | 65 | Kanamycin (Kantrex) and Ethacrynic Acid (Edecrin). Regina M. Fletcher |
| 3:30 | 66 | Alcohol and Diphenylhydantoin (Dilantin). Cleveland K. Yee |
| 3:45 | 67 | Insulin and Hydrochlorothiazide (Hydrodiuril). Sherry R. Norwitz |
| 4:00 | 68 | Monoamine Oxidase Inhibitors and L-Dopa (Levodopa). Francis S. Eng |
| 4:15 | 69 | Chlorthalidone (Hygroton) and Methyldopa (Al-domet). David L. Bennion |

*DHEW Publication No. (HSM) 73-6207

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Baltimore Metropolitan Pharmaceutical Association

A general meeting of the Baltimore Metropolitan Pharmaceutical Association was held on February 15 at the Towson Plaza Gardens. The agenda included a panel discussion entitled "A Dialogue For Pharmacists" and a legislative progress report was presented afterwards.

The panel moderated by Dean William J. Kinnard of the University of Maryland School of Pharmacy included Ronald L. Williams, Executive Secretary, American Pharmaceutical Association, Academy of General Practice of Pharmacy; Bernard B. Lachman, President, Maryland Pharmaceutical Association; Normand A. Pelissier, President, Maryland Society of Hospital Pharmacists; and Nathan I. Gruz, Executive Director, Baltimore Metropolitan Pharmaceutical Association and Maryland Pharmaceutical Association.

After each panelist presented remarks on what they thought pharmaceutical associations should do for employee pharmacists, a question and answer session was held. The program was arranged by program chairman Melvin Rubin and special thanks go to Paul Zucker for manning the refreshment center.

President Paul Freiman reviewed local, state and national legislation affecting Pharmacy and encouraged more employee participation in the Association.



Photo by Paramount Photo Service

Baltimore Metropolitan Pharmaceutical Association panel members at meeting of February 15, Towson Plaza Gardens: (l to r) Nathan I. Gruz, Executive Director, MPhA and BMPA; Paul Freiman, President, BMPA; Dean William J. Kinnard, University of Maryland, School of Pharmacy, panel moderator; Normand A. Pelissier, President, MSHP; Ronald L. Williams, Executive Secretary, APhA Academy of General Practice of Pharmacy; Bernard B. Lachman, President, MPhA. Inset: Melvin N. Rubin, Program Chairman and President Elect, BMPA.

Prince Georges-Montgomery County Pharmaceutical Association

The Prince Georges-Montgomery County Pharmaceutical Association meeting of February 5 consisted of a "Pharmacy Rally." Check off points included: Progress of Pharmacy, Economic Affairs, Health Legislation, Pending State and National Legislation, BNDD Regulations, and Continuing Education.

TAMPA News

As reported by William A. Pokorny,
Secretary-Treasurer

This year the Traveler's Auxiliary had an outstanding Oyster Roast which was held at the Penn Hotel in Towson on February 3.

The food served was delicious and the menu delightfully varied and abundant. For the first time I do believe there were no complaints from anyone. There was plenty of good fellowship and the usual enthusiastic card-playing group.

Our hats are off to our President, John Matheny, for a great job which took plenty of work and planning on behalf of him and his committee members. While passing out bouquets, let's not forget Al Turner who sold 50 tickets. Doc Kalijean, Frank Watkins, Howard Dixon, all worked hard and did an outstanding job on the Raffles. John Fagan was at the door selling 50-50's like mad and our thanks also to those who worked the wheels of chance and the other jobs which all in all made this such a successful oyster roast. By the way, John Crozier, after two years, finally received his elusive clams.

Not only was this affair outstanding as far as food and participation were concerned, but financially TAMPA came out in the black for a change.

Let's keep up the enthusiasm throughout the year 1973.

Washington County Pharmaceutical Association

Elections for the Washington County Pharmaceutical Association 1973 officers were held on January 17. The officers for 1973 are as follows: Samuel Weisbecker, President; Joseph Davies, Vice President; and Frederick Fahrney, Secretary-Treasurer. A meeting was held on February 21 at the Venice Restaurant in Hagerstown where an APhA slidetape program was presented.

Maryland Society of Hospital Pharmacists

The February 8 meeting of the Maryland Society of Hospital Pharmacists was held at the South Baltimore General Hospital. Mr. Kent Johnson, Program Chairman, introduced Donald Hamilton of the U.S. Public Health Service Hospital who gave a slide presentation of radiopharmacy. Due to a bad weather prediction which resulted in the absence of a quorum, there was no business session.

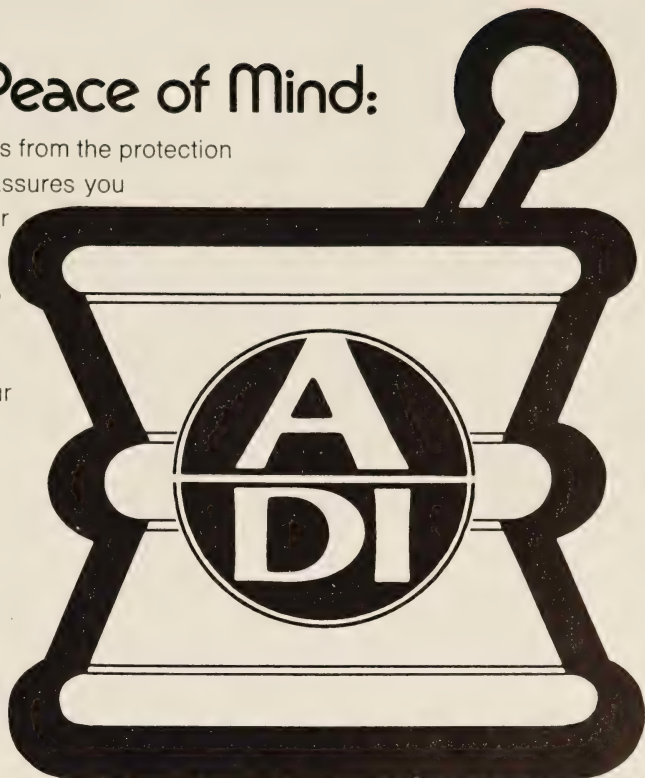
However, President Pelissier announced that the Commission on Goals of the MSHP had met with MPhA's Hospital Pharmacy Liaison Committee, chaired by Mary W. Connelly. It was agreed that the two associations would form three joint committees. The three MSHP representatives are: Robert E. Snyder, Legislative Committee; June H. Shaw, Continuing Education Committee; and Dr. Peter P. Lamy, Peer Review Committee.

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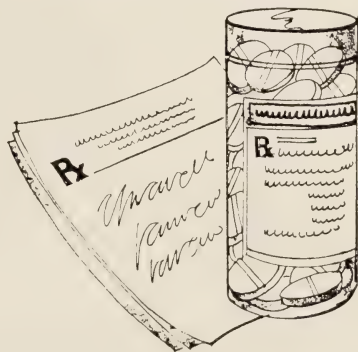
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Eastern Shore Pharmaceutical Society

The Eastern Shore Pharmaceutical Society held its first meeting of the year on February 18 in the Federalsburg Volunteer Firehouse. Topics discussed at the business meeting included a discussion of the patient profile system, announcement of continuing education seminars to be held in the area, National Poison Prevention Week, and presentation of the nominations for officers.

The after dinner speaker was Mr. Louis Lang of the Parke Davis Company whose topic was "Drugs of the Bible."



Photo by Paramount Photo Service

Eastern Shore Pharmaceutical Society meeting of February 18, 1973: (l to r) William P. Smith, President; Samuel Morris, Secretary; Louis Lang, Parke Davis Company, after dinner speaker; William Connor, First Vice President; and Thomas Payne, Treasurer.



Photo by Paramount Photo Service

Wives in attendance at February 18 Eastern Shore Pharmaceutical Society meeting in Federalsburg.

A.Z.O. News

Kappa Chapter of A.Z.O. Pharmaceutical Fraternity held a regular meeting on January 17 at the Fraternity house located at 3501 Chapman Road. A breakfast meeting was also held at the Fraternity house on February 11 featuring Special Police Agent Larry Leeson of the Baltimore City Police Department, N.W. District, Narcotics Squad. Agent Leeson spoke on "Law Enforcement Aspects of Drug Abuse."

Kappa Chapter is participating in the 1973 Heartline Telephone Campaign of the Associated Jewish Charities. Your help is needed to help man the phones. Call Henry Leikach at 922-1829 to volunteer to join in this important effort. About 25 volunteers will be needed.

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Federal, State and Local Wage and Hour Laws—

How Federal, State and City Regulations Affect the Pharmacy Owner

Labor laws are confusing, to say the least. For the Maryland pharmacy owner, first there are the federal regulations set forth in the Federal Fair Labor Standards Act. Then state laws, through the Department of Licensing and Regulations. Finally, if applicable, Baltimore City ordinances. (No other city or county in Maryland has their own ordinance covering these areas.) Where there is concurrent jurisdiction, the rule to remember is that the law providing the greater benefit to the *employee* governs.

The Federal Fair Labor Standards Act outlines provisions regarding minimum wage, equal pay, maximum hours, overtime, record keeping and child labor. How some of these provisions affect the retail pharmacist will be discussed in this article. The federal regulations apply to employees of retail and service establishments selling to the general public, which have an annual gross volume of sales of at least \$250,000. during a 12-month period. The annual gross volume of sales (hereafter referred to as AGV) must include all income from service, credit or similar charges. State, county and municipal sales taxes are levied at the retail level, and, to the extent that they are separately stated, may be excluded from the AGV.

The AGV is calculated by totaling gross receipts from all sales and/or business during the 12-month period immediately preceding the current calendar quarter beginning, January 1, April 1, July 1 or October 1. If an enterprise operates on a fiscal year, the four quarters of the fiscal period may be used in computation. The same time period must be used from year to year.

Details on all the provisions under the Federal Fair Labor Standards Act are available from the United States Department of Labor. It should be noted here that ALL business establishments are required to display a "Notice to Employees" poster which summarizes the basic requirements of the Act. A summary of Maryland Wage and Hour Laws, as well as Baltimore City (if applicable) regulations, must be posted also.

Minimum Wage Laws

The basic provisions of Maryland's minimum law are reproduced below: As of June 1, 1971, the minimum wage required to be paid in Maryland by any employer employing one or more persons is \$1.60 per hour. Generally, these regulations would apply to every pharmacy, thus overriding the Federal AGV requirement of \$250,000. This means, in effect, that most pharmacies in Maryland are required to pay a minimum wage of at least \$1.60 per hour. (See exceptions next column)

In Baltimore City, as of April 1, 1971, a pharmacy with three or more employees is required to pay a minimum wage of \$1.65 in most cases. However, there are exceptions to each of these regulations.

Exceptions

Federal regulations exempt persons employed in executive, administrative and professional capacities. State exemptions particularly applicable to pharmacies are:

82(e)(5) "Any individual who is a student regularly enrolled in primary or secondary school who is employed after school hours or during vacation for not more than 20 hours in any week" (Note that if the student works more than 20 hours he must be paid \$1.60 per hour for all the hours worked unless exempt under another subsection.)

82(e)(7) "Any individual who has attained the age of 62 years and who works not more than 25 hours per week" (Note that if the employee works more than 25 hours per week, he must be paid \$1.60 per hour for all hours worked unless exempt under another subsection.)

82(e)(11) "Any individual employed in any of the following businesses and establishments: . . . drugstores, which sell food and drink for consumption on the premises, . . ." (Note that if the portion of the business selling food and drink for consumption on the premises is a separate entity only those employees in that entity are exempt and all other employees are covered.)

Also, any student employed under an approved work study program is exempt from the minimum wage requirements.

Baltimore City ordinance exempts the following persons from its minimum wage requirements:

(c) Any employee who is a full time student in a primary or secondary school, as such term is further defined by the Minimum Wage Commission, may be paid Eighty-Five Per Cent (85%) of the minimum wage prescribed herein; provided, however, that such students may not be employed for more than twenty-eight (28) hours per week while attending school. Students enrolled in an approved work study program shall be exempt from the limitations of this subparagraph (c) and from the minimum wage requirements of this subtitle.

(e) The Minimum Wage Commission may, in its discretion, recognize certificates issued by the State of Maryland for payment of less than the minimum wage to persons who are mentally or physically handicapped, or the Commission may issue its own certificates; provided, that the Commission's said recognition or certification may be upon such terms and for such period of time as the Commission deems appropriate.

Of interest to those pharmacies whose business operations include food service, federal, state and Baltimore City regulations provide a special exception for those employees receiving tips. Federal and state regulations state that tips paid to an employee which he is permitted to keep may be credited as wages in an amount up to 50 per cent of the applicable minimum wage. If an employee can show that he is receiving less in actual tips than the amount credited, the employer must pay the difference so that the employee receives at least the minimum wage. Baltimore City does add one qualification to this: "In an

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occupation in which (the employee) customarily and regularly receives more than \$20.00 per month in tips . . ."

Also, under federal and state laws, the reasonable value of meals provided by the employer is considered wages. Under Baltimore City ordinance, the reasonable value of uniforms provided by the employer may be counted as wages.

Overtime Laws

What about overtime? Federal and state laws require time and one half be paid for all hours in excess of 40 per week to all non-exempt employees. The same exemptions that apply to the minimum wage on both a federal and state basis also apply here. The federal Act also exempts employees of retail or service establishments who are employed more than 50 per cent of the time in connection with the preparation and/or serving of food and beverages. Also, persons employed as drivers or drivers' helpers, making local deliveries and who are compensated on a trip-rate basis. (The Maryland exemption most applicable to the pharmacy owner regards food service employees, as listed above.) Baltimore City has no overtime ordinance.

"Hours worked" as stated in the overtime regulations includes all time an employee is required to be on the employer's premises or on duty. Bonafide meal periods during the scheduled work day are not "hours worked" time if the employee is completely relieved from duty. If the meal periods are frequently interrupted, the employee would not be considered relieved of all duties, and the meal period must be counted as hours worked. Coffee breaks must be counted as hours worked.

Child Labor Laws

Laws affecting the employment of minors overlap with some of the minimum wage regulations. As discussed above, the minimum wage laws as they apply to the student employee are as follows: Federal and Baltimore City regulations require a wage of only 85 per cent of the stated minimum for hours worked not in excess of 28 per week. The state of Maryland, however, provides for full minimum wage for all hours in excess of 20 per week. So, unless a retail or service establishment is exempt from the Maryland law, minimum wage is required for hours in excess of 20.

Under the child labor laws of Maryland, minors not enrolled in school may work 9 hours per day, 48 hours per week (but any minor under 16 is required to attend school unless necessary exemption forms have been filed). These minors are covered under the wage requirements, just as any other employee would be. Students, aged 16 and 17, may work no more than 5 hours per day and 30 hours per week when school is in session. They are also limited to employment between the hours of 6 a.m. and 11 p.m. When school is not in session they may work an 8 hour day, 40 hour week. Students, aged 14 and 15, may not work more than 23 hours per week and no later than 7 p.m. at night.

There are several restricted occupations for minors 16 and 17 years of age under the federal law. The only restrictions affecting the retail drug store however, is

that a minor may not be employed as an operator of any motor vehicle.

Minors 14 and 15 years of age come under further restrictions as outlined by the Maryland State Department of Labor:

Minors 14 and 15 years of age may not be employed in manufacturing, mining, processing, transportation, warehousing, storage, communications, public utilities, construction, public messenger service and workroom where goods are manufactured or processed. They may not work in or about engine or boiler rooms, machine maintenance and repair, or upon ladders or scaffolding. They are prohibited from employment on a boat, in dry cleaning processing plants, and plants where tobacco is processed, paints packed, acid and dangerous or poisonous gases are used, or in dust causing occupations. They may also not be employed in or about a theater, concert hall, cabaret, rodeo, carnival, poolroom, billiard parlor or bowling alley.

What minors 14 and 15 are allowed to do includes:

Minors of 14 and 15 may be employed in office and clerical work, including operation of office machines, cashing, selling, window trimming, kitchen work, food service and operating and cleaning dishwashers, toasters and milk shake blenders. They may mark merchandise and stock shelves.

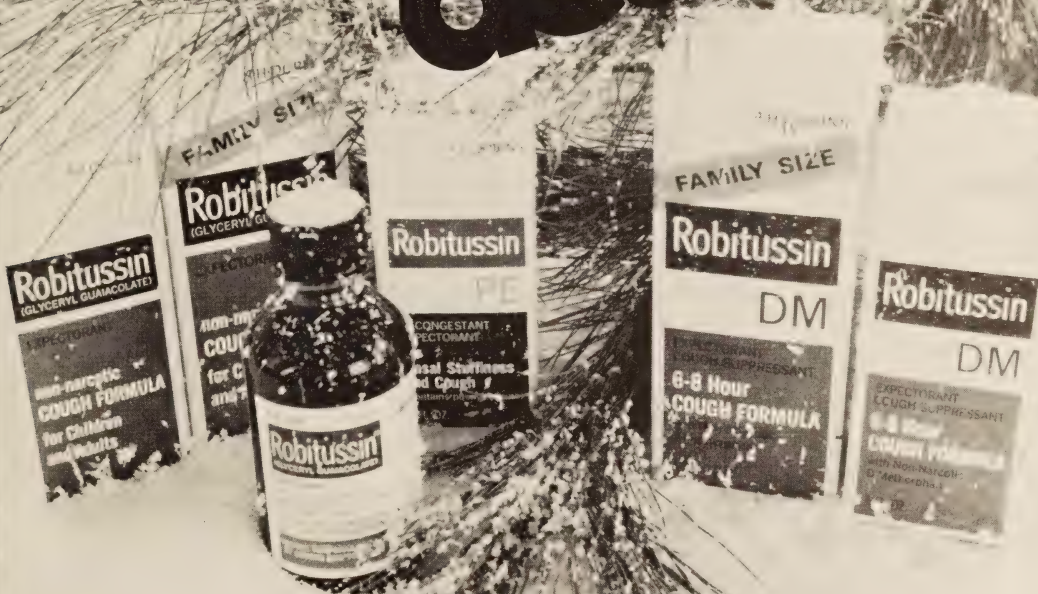
Employers are required to keep records of wages and hours, as well as age or state employment certificates for minors. Records must be kept for three years, except for time cards which may be destroyed after two years. Required records must contain the following information: full name of employee, home address including zip code, date of birth if under 19, sex and occupation, time of day and day of week on which workweek begins, regular hourly rate of pay, daily and weekly hours of work, total daily or weekly straight time earnings, total overtime compensation for the workweek, total additions to or deductions from wages paid each pay period, total wages paid each pay period, date of payment and pay period covered by each payment.

Authorized representatives of the federal, state or city government may investigate and gather data regarding hours, wages and other practices of employment. Also note:

(G) An employee may not be discharged for filing a complaint or participating in a proceeding under law. Willful violations may be prosecuted criminally and the violator fined up to \$10,000. A second conviction may result in imprisonment. Violation of state law is punishable upon conviction by a fine of not less than \$200, nor more than \$1,000. A \$500. fine is imposed upon convicted violators of the rules and regulations of Baltimore City and is termed a misdemeanor.

Further information may be obtained as well as posters and summaries in compliance with requirements (free of charge) by calling the following telephone numbers: Wage and Hour Division (federal), 962-2265; Department of Labor and Industry (state), 383-2259; Minimum Wage Commission (Baltimore City), 752-2000, extension 2284.

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Media Point Out Important Role of Pharmacist In Drug Interactions Area

Several articles have appeared recently in newspapers and magazines pointing out the benefits in the use of individual medication profiles in preventing possible adverse drug interactions.

An article appearing in the March 5, 1973 issue of *Time* magazine points out how the physician knows the dangers of drug antagonism but is not always aware of all the medications that patient may be taking, especially those bought without prescription. "The patient knows what he is taking, but is rarely aware of the dangers. But," the article continues, "there is someone in a position to know both the drugs being taken and the harm that wrong combinations can cause the pharmacist. By keeping a medication profile of each steady customer and referring to it each time he fills that customer's prescriptions or sells him over-the-counter drugs, he can prevent the possibility of a harmful reaction."

A similar article appearing in a recent edition of the *Baltimore Sun* was based on an interview with Paul Freiman, President of the Baltimore Metropolitan Pharmaceutical Association. Mr. Freiman related how a quick check of a patient's profile card in his pharmacy could have averted tragic consequences. The patient was taking eye drops daily for a glaucoma condition and was issued a new prescription from another doctor for a drug to control a stomach problem. The second drug, an anticholinergic, would have increased intraocular pressure. The article was entitled "Prescription pad roulette: the drugstore may save your life."

In The News . . .

W. LUTHER SKINNER, Jr., was appointed as President of McKENNA SURGICAL SUPPLY, Inc., a subsidiary of HENRY B. GILPIN COMPANY. MARK J. GOLIBART, Professional Representative for ABBOTT LABORATORIES, has been selected to become a Regional Sales Trainer for Abbott Laboratories in the East-

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Nathan I. Gruz, Editor
Maryland Pharmacist
650 West Lombard Street

ern Region. MICHAEL SKINNER, 1968 graduate of Morgan State College, has been appointed Head, Office of Minority Affairs, University of Maryland, SCHOOL OF PHARMACY. JOHN G. WAGNER, Ph.D., of the UP-JOHN Center for Clinical Pharmacology and the University of Michigan School of Pharmacy, was guest speaker at the Visiting Lecturer Program of the University of Maryland, SCHOOL OF PHARMACY on February 15, 1973. His topic was "Relationship of Serum Creatinine Concentration and Endogenous Creatinine Clearance to Equilibrium State Plasma Concentrations of Digoxin." He also delivered a second lecture entitled "Comparison of the Bioavailability of Four PAS Dosage Forms."

Drug Fair Announces Personnel Changes

ROBERT A. OSBORN was named Director of Store Operations for Drug Fair, Inc., where he will be responsible for directing the retail pharmacy chain's 140 stores. Drug Fair also named MPhA member MARION SHALOWITZ Director of Purchasing and Inventory Control; MPhA member EDWARD L. CATTERTON to District Manager in charge of stores in Arlington, Alexandria, Falls Church and Fairfax County; STUART M. ELSEBERG to Vice President; and STANLEY H. HOROWITZ to Secretary.

Obituaries

Dr. Jerome E. Goodman

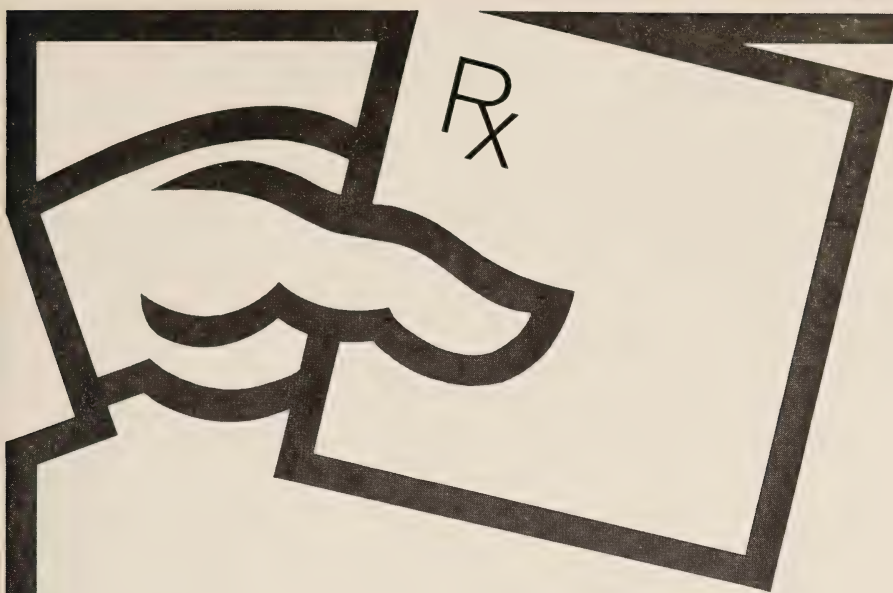
Dr. Jerome E. Goodman, 70, a 1924 graduate of the University of Maryland, School of Pharmacy and 1928 graduate of the School of Medicine, died on February 9. He was a gynecologist on the staff of Sinai Hospital for the last 40 years.

Thomas E. R. Fields

Thomas E. R. Fields, former proprietor of Field's Pharmacy in Pikesville, died on February 15 following a heart attack. Mr. Fields, who was 78, was a former member of the Maryland Pharmaceutical Association and was a member of the advisory board of the Loyola Federal Savings and Loan Association. He graduated from the University of Maryland, School of Pharmacy in 1921.

Harry Elliott Ward

Harry Elliott Ward, 82, one of the last assistant pharmacists, died on February 21. He was formerly employed by Hynson Westcott & Dunning.



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the maryland pharmacist

MARCH
1973
Volume 49
Number 3

ABSTRACTS

*First Annual Symposium
on*

Pharmacology and Therapeutics

*University of Maryland
School of Pharmacy*

May 1, 1973

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An Explanatory Mailing, scheduled for early February, will include a letter describing the program, a 6-part return goods form listing the approximately 95 items discontinued over the years, and a BRC for pharmacies which have no returnable merchandise.

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Our Established Return Goods Policy is in no way altered by this special campaign. Only those products specified in the returned goods form may be returned under this program; other unsalable Roche items must be handled separately and in the customary manner.

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The Maryland Pharmacist

NATHAN I. GRUZ, *Editor*
NORMAND A. PELISSIER, *Assistant Editor*
ROSS P. CAMPBELL, *News Correspondent*
HERMAN J. BLOOM, *Photographer*

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BALTIMORE, MARYLAND 21201
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MAINTAINING PROFESSIONAL COMPETENCY

Today every health professional must pursue a program of continuing education, if he aspires to maintain his professional competency. The public expects every professional to take whatever steps are necessary to assure that his knowledge is in a current state. Thus professional responsibilities may be discharged within the capabilities of newer knowledge and developments in pharmaceutical and medical sciences.

An excellent opportunity to acquire information on drug interactions will be the First Annual Symposium on Pharmacology and Therapeutics to be held on May 1. The Symposium was planned by Dr. Gary Buterbaugh, assistant professor of pharmacology and toxicology at the University of Maryland School of Pharmacy, with papers to be presented by the fourth year students.

The program was printed in the February issue of *The Maryland Pharmacist*. The abstracts are published in this issue and are worth the attention of all persons seeking to develop the knowledge and proficiency in an important aspect of the emerging discipline of "Clinical Pharmacy."

The School of Pharmacy and the participating students are to be commended for this important contribution to the profession.

All pharmacists are invited and urged to attend this unique program.

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ABSTRACTS

Of Papers to be Presented at the Pharmacology and Therapeutics Symposium on Drug Interactions

TUESDAY MORNING, May 1, 1973

Room 201, Allied Health Professions Building,
32 South Greene Street

Chairman: Francis J. Meyer, Ph.D.

8:45

1. ALCOHOL-MONOAMINE OXIDASE INHIBITORS. *David C. Curry*

MAO inhibitors cause their antidepressant actions by preventing the enzyme catalyzed degradation of endogenous amines, via complexation with the enzyme. This causes an increase in the levels of norepinephrine, dopamine, and 5-hydroxytryptamine in the brain and other tissues. Substances which stimulate the release of norepinephrine from nerve terminals greatly increase sympathetic activity during MAO therapy. Because ethanol causes norepinephrine release it has been indicated in precipitating hypertensive crises as well as milder reactions such as severe headache. Due to a large number of adverse reactions and side effects monoamine oxidase inhibitors are falling into disuse. However, the danger of an interaction with MAO inhibitors is still significant because of the universal availability of alcohol. The treatment of hypertensive crises due to MAO ethanol interaction is a short acting adrenergic blocker (e.g. phentolamine) given I.V.

9:00

2. RESERPINE (SERPASIL)-DIGITALIS. *William V. Zappa*

The fact that reserpine and digitalis cause certain pharmacological effects when administered concurrently has been widely recognized, and there have been numerous reports of bradycardia, atrial arrhythmias, and ectopic ventricular activity. Although the specific mechanism of interaction between these two drugs has not been clearly elucidated, some researchers have postulated from experimental data that the interactions caused by these drugs are based on the effect each drug has on myocardial catecholamines. A more likely possibility is that reserpine's bradycrotic action facilitates a discharge from an irritable focus and that the arrhythmias may simulate digitalis intoxication. Such interactions as here listed do not indicate incompatibility of reserpine and digitalis. Advantage may be taken of these effects by using decreased doses of both drugs, lessening hazards of digitalis toxicity.

9:15

3. MONOAMINE OXIDASE INHIBITORS — TYRAMINE. *Barry L. Luria*

Monoamine oxidase inhibitors are used in the treatment of depression. The inhibitor works by irreversibly complexing with the enzyme MAO. This in-

hibition allows for the increased release and longer duration of action of catecholamine sympathomimetic transmitters such as norepinephrine. With MAO inhibited it is also possible for exogenous sympathomimetic amines to exert an effect on the nervous system. Tyramine is one such sympathomimetic which is found commonly in cheese and some wines. Normally, the MAO of the intestinal cells and liver cells prevent tyramine from reaching the nerve cells but under MAO inhibition the tyramine and other active amines such as dopamine are able to reach these cells. Tyramine acts on the nerves to release norepinephrine from its storage pools in the nerve, thus greatly increasing the effect of MAO inhibitor treatment. The side effect of this additive effect is a hypertensive crisis which can be fatal to the patient. The best known preventive measure for this interaction is to warn the patient to avoid those foodstuffs which are known to contain tyramine and other sympathomimetic amines.

4. SPIRONOLACTONE (ALDACTONE) — COUMARINS. *Dennis L. Meyers*

It has been found that spironolactone can enhance NADPH-dependent mixed function oxidation in liver microsomes thus accelerating the production of polar metabolites and the disappearance of drugs from blood. Since coumarin is metabolized by these liver enzymes, there is a potential interaction between these two drugs. There are few reports of the spironolactone-coumarin interaction, but there is supportive data to show that when the two drugs are administered together there is significant reduction in blood levels of coumarin, returning the prothrombin time to pretreatment values in some cases. Great care should be exercised in patients on anticoagulant therapy and treated previously or conjointly with spironolactone. Not only prothrombin time but also the blood concentration of the anticoagulant should be checked.

5. PROPRANOLOL (INDERAL) — HYPOGLYCEMIC AGENTS. *Harold D. Harrison*

Recently in the literature, cases of hypoglycemic coma have been reported in patients on propranolol therapy. Hypoglycemic agents act to lower the level of glucose in the blood. During hypoglycemia, epinephrine is released as a counter regulatory hormone to restore the normal plasma level of glucose by increasing glycogenolysis in the liver and peripheral tissue. Propranolol interferes with this hyperglycemic effect of the catecholamines liberated in response to the powerful stimulus of hypoglycemia. Propranolol also potentiates the effect of insulin through inhibition of epinephrine stimulated glycogenolysis. Because diabetes mellitus and coronary heart disease often co-exist and it is likely that some patients will receive hypoglycemic agents and propranolol simultaneously, propranolol should be used with caution in patients prone to hypoglycemia and those patients taking hypoglycemic agents.

10:00

6. GUANETHIDINE (ISMELIN) — AMITRIPTYLINE (ELAVIL). *Dorothy H. Humphreys*

Guanethidine, an agent used in moderate to severe hypertension, acts by being taken up into adrenergic neurons by the same mechanism that is responsible for the reuptake of norepinephrine. Amitriptyline, as well as the other tricyclic anti-depressants, blocks the uptake of guanethidine into the adrenergic neuron, antagonizing the hypotensive effect of guanethidine and causing a consequent rise in blood pressure. A change in therapy is recommended from desipramine, amitriptyline, or protriptyline to doxepin which from evidence is not likely to alter the effects of guanethidine in normal therapeutic doses.

10:15

7. DISULFIRAM (ANTABUSE) — DIPHENYLHYDANTOIN (DILANTIN). *Leslie A. Benson*

Epileptics being controlled with Diphenylhydantoin exhibit marked increases in serum levels of DPH when given Disulfiram. Normally DPH is inactivated in the liver by para-hydroxylation but in the presence of Disulfiram this process is inhibited resulting in elevated levels of DPH, and the consequent possibility of toxic manifestations. Clinical investigations revealed withdrawal of Disulfiram showed no immediate leveling off in serum concentrations but a period of three weeks were necessary for normal conditions to be re-established. The combined therapy should be avoided, or if given, followed closely with clinical examination of the DPH concentration in the serum. A possible recommendation would be to substitute Disulfiram with Calcium Carbimide, a drug similar in therapeutic action as Disulfiram, but with no significant change in serum concentrations of DPH nor the mean excretion rate of the converted metabolite.

10:30

8. PROBENECID (BENEMID) — THE PENICILLINS. *Wayne A. Borkoski*

The pharmacological actions of probenecid are assumed to be largely confined to the inhibition of active renal tubular secretion of weak organic acids. Since tubular secretion is the major elimination pathway for the penicillins, administration of probenecid in conjunction with penicillin given by any route results in higher and more prolonged plasma concentrations of the antibiotic than when given alone. Probenecid sets up this "favorable interaction" by modifying both the distribution and elimination of penicillin. Clinical studies have shown convincing results on the efficacy of this interaction. Before the development of the long acting depot penicillins this interaction was presumably of great clinical significance but presently it can only be considered as an alternate means of increasing and prolonging serum penicillin levels.

10:45

9. NEOMYCIN — NEUROMUSCULAR BLOCKING AGENTS. *Elwood L. Fletcher*

Aminoglycoside antibiotics, especially Neomycin, have been shown to produce a neuromuscular blockade which may enhance the blockade of skeletal muscle relaxants, possibly resulting in respiratory paralysis. The mechanism of action of the neuromuscular blocking activity of neomycin appears to be curare-like in that it potentiates neuromuscular blockade by curare and is reversed by neostigmine. Oral, intraperitoneal, and intramuscular administration of neomycin have been documented to cause potentiation of neuromuscular blocking agents. The best management of the interaction is extreme caution in administering neomycin or other aminoglycosides during surgery or in post-operative period, as the effect of surgical neuromuscular blocking agents may be enhanced. To counteract this interaction both anticholinesterases and calcium have been used with varied results.

11:00

10. PYRIDOXINE (VITAMIN B₆)—PARKINSONISM DOPA REGIMENS. *Carroll G. Rusk, Jr.*

Dopa Therapy in parkinsonism is based on correction of an imbalance in cholinergic excitatory and dopaminergic inhibitory CNS activity by dopamine repletion via precursor loading, though this may not be its only therapeutic mechanism. Dopa interacts with pyridoxine at more than one level of clinical importance being pyridoxine-increased decarboxylation of dopa. Pyridoxine acts as cofactor to dopa decarboxylase by a mechanism which is poorly understood. In slightly greater-than-dietary quantities, pyridoxine may reverse effects of dopa. However, when included in a regimen of dopa and peripheral decarboxylase inhibitor (Mk 486 or Ro4-4602) it may actually enhance therapeutic effect. Research may soon cause a regimen of dopa, peripheral decarboxylase inhibitor, pyridoxine and anti-cholinergic (Amantadine or Orphenadrine) to become standard parkinson therapy. The pharmacist's current role is one of vigilance in regard to the patient's B₆ intake and symptoms of dopa refraction as well as possible pyridoxine deficiency. The probability of future developments in multi drug therapy based on this interaction, and the nature of the drugs' effects, affords good opportunity for the pharmacist to take an active role in determining the parkinson patient's therapeutic regimen.

11:15

11. DIAZEPAM (VALIUM) — INTRAVENOUS BARBITURATE. *Frank Vocci*

Diazepam is effective in the control of status epilepticus and should be the drug of choice. The depressant effects of Diazepam on the central nervous system provides the only hazard of treatment. Respiratory depression has been reported to have occurred after treatment with both intravenous diazepam and barbiturate. In a British study, a series of twenty-five (25) pa-

tients were admitted with status epilepticus. The patients were maintained on previous anti-convulsant regimens and given diazepam which promptly arrested the status in 11 patients (44%). Phenobarbital was administered intramuscularly (1.M.) when there was a poor or limited response to diazepam. Of these patients, respiratory depression occurred in one and hypotension in five others. One case of hypotension had a fatal outcome but the patient had also been administered diphenylhydantoin and paraldehyde. In the case of respiratory depression, 2.5 mg. of diazepam produced Cheyne-Stokes breathing for one hour. Patients in status epilepticus seem to be extremely susceptible to depressant effects of drugs. Care should be exercised in the administration of CNS depressants which may act synergistically.

Room 217, Allied Health Professions Building,
32 South Greene Street

Chairman: John B. Young, Ph.D.

8:45

12. TOLBUTAMIDE (ORINASE) — SALICYLATES. *Philip M. Perry*

Tolbutamide acts to lower the concentration of sugar in the blood by two mechanisms: first, by a stimulation of the Beta cells in the pancreas and secondly, by reducing glucose output from the liver. Salicylates, in high doses, also exert a lowering of blood sugar but the mechanism of action is not clear. The class of sulfonylureas (of which Tolbutamide is a member) are bound to albumin molecules but are displaced from these binding sites by more strongly bound compounds such as the salicylates, phenylbutazone, etc. This results in a potentiation of the hypoglycemic of Tolbutamide. Although evidence is lacking to support the clinical significance of the interaction, the physician, pharmacist and patient should be aware of the possibilities and should avoid the concurrent use of the salicylates and sulfonylurea compounds.

9:00

13. TOLBUTAMIDE (ORINASE) — COUMARINS. *Florence F. Kwong*

Coumarin inhibits the enzymatic conversion of the methyl group on tolbutamide to the carboxyl group. The reduction of metabolism of tolbutamide may produce episodes of protracted hypoglycemia due to the accumulation of tolbutamide in the blood. On the other hand, when tolbutamide is given under the coumarin treatment, anticoagulant activity is first potentiated due to displacement of coumarin from binding sites on plasma protein, and then antagonized because of the stimulatory effect on the metabolism of coumarin by enzyme induction. Clinical study shows that tolbutamide's half life is increased and blood sugar level is lowered to a great extent with combined anticoagulant therapy. Animal studies reported death of dogs and in-

stances of spontaneous bleeding due to potentiation of anticoagulant, and followed by side effects of tolbutamide overdose. In light of these, the use of phenindione is recommended since it does not affect the metabolism of tolbutamide. The order of administration of drugs is important in determining the interactions of coumarin and tolbutamide since reports have shown that the anticoagulant activity was not altered in diabetic patients who had received long-term tolbutamide treatment prior to the addition of coumarin.

9:15

14. RESERPINE (SERPASIL) — ANTICONVULSANTS. *Chris J. Economides*

Pretreatment with Reserpine will facilitate and prolong convulsions in laboratory animals. Reserpine inhibits or prevents the uptake of catecholamines in nerve granules. Therefore in effect it not only blocks ATP dependent uptake of norepinephrine, but possibly blocks the synthesis of norepinephrine by inhibiting the uptake of dopamine also. In addition, Reserpine tends to slow the release of norepinephrine from the storage granules. With relation to these effects, an antagonistic mechanism has been proposed for Reserpine's interaction with some anticonvulsants. These are Acetazolamide and Chlordiazepoxide which have been shown to be antagonized by Reserpine and other amine depletors as well. Dephenylhydantoin on the other hand has not been shown to be antagonized by depletors other than Reserpine. Another mechanism of interaction is in effect here. Studies on Reserpine's mode of interaction with other anticonvulsants are not available. Clinical reports are extremely rare, if at all existent. This is probably a consequence of the fact that hypertensive-epileptics are themselves rare. It has been reported that Reserpine effects are evidenced up to four weeks after therapy has been discontinued, but no official clinical trials have been made to support this. Newly diagnosed epileptics should be given a substitute for Reserpine and kept under observation for about four weeks. Reserpine therapy should be avoided in known epileptics.

9:30

15. NARCOTIC ANALGESICS — MAO INHIBITORS. *Nickola L. Kuhn*

A better title would be "Meperidine and MAO Inhibitors" as it is the only significant interaction to occur. Two mechanisms have been considered responsible: 1) Inhibition of meperidine biotransformation, and 2) elevation of 5-hydroxytryptamine (5-HT) levels in the brain. MAO inhibitors are known to inhibit several enzyme systems other than monoamine oxidase. However, the speed of the toxic reaction, animal studies, and the symptoms (different from meperidine alone) suggest increased 5-HT level as a more likely mechanism. There have been at least a dozen case reports on this interaction, which has a quite noticeable onset. Death occurred in two or three cases. Therefore, the reaction is severe enough to warrant avoid-

ance of meperidine administration to patients already on MAO inhibitors and for two to three weeks past discontinuance. Effective therapy has been chlorpromazine during the restless stage and prednisolone hemisuccinate during unconsciousness.

9:45

16. TRICYCLIC ANTIDEPRESSANTS — ETHYL ALCOHOL. *Barry L. Keeler*

Tricyclic antidepressants are generally believed to inhibit the reuptake of neurotransmitters (norepinephrine and/or serotonin) into the nerve endings of the brain, thus making more of the neurotransmitter available for the receptors and therefore alleviating depression. A common side effect observed with tricyclic antidepressants is sedation. Since ethyl alcohol is known to be a CNS depressant, the combined effects of the two drugs may lead to a more serious depression of the CNS. This interaction is one that is often neglected since it seems irrational that a mood elevator would add to the CNS depression of alcohol. This interaction could be of serious consequences to a person who normally can "hold his liquor" but after taking tricyclic antidepressants may have a serious CNS depression. To prevent this severe CNS depression it is necessary to warn patients that their tolerance to alcohol will be lowered while taking tricyclic antidepressants.

10:00

17. PHENOBARBITAL — BISHYDROXY-COUMARIN (DICOUMAROL). *Robert J. Martin*

Phenobarbital may decrease the therapeutic effectiveness of bishydroxycoumarin and other related anticoagulants. There are two mechanisms which cause this loss of activity. First, phenobarbital induces microsomal enzymes in liver which increases the rate of metabolism of the bishydroxycoumarin. Second, phenobarbital decreases the gastrointestinal absorption of the bishydroxycoumarin when given orally. This is a clinically significant interaction and serious consequences may arise if these drugs are given concomitantly without frequent prothrombin determinations and the required adjustments.

10:15

18. ALCOHOL — INSULIN. *Frances H. Cohen*

Insulin acts to increase glucose transport independent of the rate of phosphorylation. Thus, too much insulin can cause hypoglycemia. Prolonged hypoglycemia can result in many complications including brain damage and even death. Alcohol (ethanol) can cause and/or prolong hypoglycemia, but by another mechanism. Alcohol interferes with glyconeogenesis by increasing the ratio of reduced to oxidized nicotinamide adenine dinucleotide (NADH₂/NAD) within the hepatic cells during the oxidation of alcohol. Increasing the NADH₂/NAD ratio inhibits glycerol, lactic acid, and specific amino acids from enter-

ing the metabolic pathways through which these metabolites are converted to glucose. Alcohol appears not to have a direct effect on plasma glucose as does insulin, but it does have an effect on the mechanism of counter regulation of plasma glucose levels which, in effect, is an additive action on the hypoglycemia of insulin. Although there is not an overabundance of clinical data on this interaction, what is available is substantial to warrant caution in the concomitant administration of alcohol and insulin.

10:30

19. ANTICHOLINERGICS — PHENOTHIAZINES. *Kim P. Fisher*

Anticholinergics suppress an overactivity of the parasympathetic nervous system, and are thought to depress the reticular activating system. The phenothiazines possess anticholinergic properties, as well as antihistaminic and antiserotonin properties. The effects of anticholinergics are potentiated by the phenothiazines, causing a marked central nervous system depression, often resulting in a sleep-like coma. The exact mechanism of the potentiation is not known, but the effects are not merely thought to be additive. This potentiation seen after acute administration may last for weeks or months, and the behavioral effects of the patient may be altered drastically.

10:45

20. GRISEOFULVIN — PHENOBARBITAL. *William R. Addington*

Earlier reports indicate that phenobarbital may increase the metabolism of griseofulvin by hepatic microsomal enzyme induction. However, more recent evidence from pharmacokinetic studies has shown that phenobarbital impairs the absorption of griseofulvin. Although decreased plasma levels of griseofulvin are well documented, the effect of these decreases on therapeutic response has not been established. A report of a single case of possible impaired therapeutic response to griseofulvin was cited by Riegelman and his associates, but more study is needed to assess the clinical significance of this interaction. Pending further information, it would be preferable to avoid giving phenobarbital to patients receiving griseofulvin. If concomitant therapy is desired, it is suggested that divided doses (e.g. three times a day) of griseofulvin may be absorbed better than larger doses taken less often. Whether an increase in the daily griseofulvin dose is warranted requires further study.

11:00

21. ATROPINE — MEPERIDINE (DEMEROL). *Claude W. Nogay*

The belladonna alkaloids, which include atropine (dl-hyoscyamine), competitively antagonize the muscarinic actions of acetylcholine and are therefore known as anti-muscarinic agents. In line with this activity, atropine blocks the responses of the sphincter muscle of the iris of the eye and the ciliary muscle of the lens

to acetylcholine. Although atropine has little effect on intraocular pressure of the normal eye, if the intraocular pressure is initially above normal, as in narrow angle glaucoma, atropine will elevate the pressure even more and is thus apt to damage glaucomatous eyes. Meperidine, a synthetic analgesic, increases this effect of atropine and thus should be used with care in patients with glaucoma, particularly given the widespread occurrence of atropine in prescriptions and non-prescription medications.

11:15

22. PREDNISONE — ISONIAZID (NYDRAZID) *Harry J. Williams*

Tuberculosis is considered to be a contraindication to Corticosteroid therapy. It would seem therefore that the practicing pharmacist would have cause for concern if Prednisone and Isoniazid were prescribed for the same patient, since TB is the only major indication for Isoniazid. Most studies, however, indicate that there is no true drug-drug interaction involved, and that corticosteroids in combination with the proper chemotherapy, such as Isoniazid, may actually be beneficial in many cases of tuberculosis. The real hazard is in the treatment of tuberculin-positive patients with corticosteroids, who are NOT receiving antitubercular drugs, because the anti-inflammatory action of the corticosteroids can open up tubercles and activate a case of latent tuberculosis.

Health Sciences Library Auditorium Chairman: David R. Brown, Ph.D.

8:45

23. TETRACYCLINES — MULTIVALENT CATIONS. *Paul L. Fader*

Tetracyclines are known to cause gastrointestinal distress, nausea and vomiting; therefore, antacids, milk and food have been administered to reduce these side effects. However, the tetracyclines may be chelating agents that form insoluble chelates with multivalent cations, Ca^{++} , Mg^{++} , Al^{+++} or may be absorbed on the colloidal particles of antacids. The result has been to inhibit the absorption of the tetracycline from the gastrointestinal tract. What happens then is a therapeutically significant reduction in tetracycline blood levels resulting in inadequate therapy and suboptimal response. From a review of the literature the most effective absorption of tetracyclines will be on an empty stomach. However, if nausea and vomiting become a problem non-dairy food would be the best treatment for these effects. The concurrent use of antacids and dairy products should be avoided at all cost to the patient when on tetracycline therapy.

9:00

24. DIPHENHYDRAMINE BENADRYL) — ANTICHOLINERGICS. *Benjamin E. Carter*

Diphenhydramine (BENADRYL—Parke Davis) is an antihistaminic drug with an incidence of side

effects of 30-60%; among these side effects are dryness of mouth and nose suggestive of anticholinergic properties. As such it can cause potentiation of anticholinergic side effects of other drugs with slight anticholinergic properties, notably thioridazine (MELLARIL—Sandoz) and amitriptyline (ELAVIL—Merck, Sharpe & Dohme). The combination of products produces symptoms of dryness of mouth, tongue dried and furred with fissuring, drying of lips and cracking at the angles of the mouth, and dizziness with disorientation, to an extent not previously reported as side effects to normal dosage of either drug. This potentiation would indicate close monitoring of a patient receiving diphenhydramine concurrently with any drug possessing anticholinergic side effects and most certainly with a drug whose main effects are anticholinergic.

9:15

25. DIPHENYLHYDANTOIN (DILANTIN) — VITAMIN D METABOLISM. *Bonnie L. Pitt*

Vit D resembles the adrenocortical hormones in structure and undergoes the same metabolism by the hepatic P450 system. In several studies it was found that approximately 22-33% of patients on single and combined anticonvulsant therapy (primarily DPH and phenobarbital) showed a subnormal calcium level. Some cases of severe osteomalacia were found in isolated reports. It has been suggested that anticonvulsant therapy induces hepatic microsomal enzymes, increasing the metabolism of Vit D to polar metabolites, other than the active one, 25-hydroxycalciferol. Also, the metabolism of 25-hydroxycalciferol is increased. The interaction is more likely to occur in blacks and people on insufficient diet. The reaction is easily reversible by exogenous Vit D.

9:30

26. GUANETHIDINE (ISMELIN) — L-DOPA. *Milton Proudfoot*

The interaction begins with the conversion of L-DOPA by dopa decarboxylase to dopamine. This is in turn acted on by dopamine oxidase to norepinephrine. This increase in the amount of neurotransmitter causes an increase in the number of granules in presynaptic cells. It is reported that guanethidine releases these stores into the synaptic cleft. This increases the chance of sympathetic overstimulation, which may cause an increased chance of sympathetic side-effects (not uncommon to these two drugs). The first being hypertension and followed by eventual reversal to Parkinson-like tremors. Since elderly people are more prone to Parkinson tremors and are now being treated with L-DOPA, the significance of this interaction becomes more important, since the cardio-vascular systems of these people may already have complications and may not withstand this added strain.

9:45

27. ACETOHEXAMIDE (DYMELOR) — PHENYLBUTAZONE (BUTAZOLIDIN). *Thomas S. Shelor*

Phenylbutazone displaces acetohehexamide from its protein binding sites since it is more protein-bound than acetohehexamide. In addition, phenylbutazone increases the circulation time of acetohehexamide's major active metabolite, hydroxyhexamide. The net effect of these events is a sulfonylurea-induced hypoglycemia. There have been few reported cases of this interaction in the past ten years but it is potentially serious. Recent studies indicate that the hypoglycemia is only temporarily reversed by the administration of glucose, because the beta cells become hyper-responsive to insulinogenic stimuli as a consequence of this interaction. Ideally phenylbutazone should not be given to the diabetic stabilized on acetohehexamide, but if necessary the dosage of acetohehexamide must be decreased correspondingly by retitering the diabetic patient.

10:00

28. PROPRANOLOL (INDERAL) — CARDIAC GLYCOSIDES. *Stanley J. Stefanoski*

Propranolol has been advocated for use in the treatment of Digoxin-induced cardiac arrhythmias. It has even been specified as an antagonist of digoxin. However, documented cases indicate a sensitivity to propranolol which produced bradycardia and a synergistic action has been postulated. This dangerous and possibly fatal situation may be averted by use of test doses of propranolol or that atropine be routinely administered along with propranolol to patients who have received digoxin therapy.

10:15

29. WARFARIN (COUMADIN) — CHLORAL HYDRATE (NOCTEC). *Stanton G. Ades*

Chloral hydrate has been reported to potentiate the activity of warfarin by displacing it from its protein binding sites. This occasionally important interaction during clinical use leads to transient hypoprothrombinemia due to the increase in warfarin plasma concentration. This displacement of warfarin from albumin immediately increases the rate of its metabolic inactivation and renal clearance and shortens its half life. This is followed by a progressive fall in total and free warfarin concentration in the plasma and by a gradual subsidence of the potentiation of hypoprothrombinemia. The same effect has been shown with bishydroxycoumarin. Excessive anticoagulant effect may occur as early as 12 hours after initiation of chloral hydrate in a dosage of 1.0G., and a 40-80% increase in hypoprothrombinemia has occurred after 7 days. The problem can be prevented or controlled by reducing the dose of warfarin when chloral hydrate therapy is initiated and then increase the dose when therapy is stopped, or by using another sedative/hypnotic, preferably a non-barbiturate.

10:30

30. MONOAMINE OXIDASE INHIBITORS — AMPHETAMINES. *Harry N. Cook*

Monoamine oxidase inhibitors act by irreversibly blocking monoamine oxidase thereby augmenting and prolonging the effects of substrates of this enzyme. Indirect acting sympathomimetic amines such as amphetamines and ephedrine are potentiated because they may release increased amounts of norepinephrine from sympathetic nerve endings after MAO inhibition. Hypertensive crisis may be the expected outcome in nearly all patients receiving sympathomimetic amines and MAO inhibitors concomitantly. Fatal reactions have been reported in patients taking Tranylecypromine with either amphetamine, methamphetamine, or ephedrine. Preventive measures should include the use of other antidepressants before MAO inhibitors and perhaps an identification bracelet/necklace for patients taking MAO inhibitors.

10:45

31. THYROID REPLACEMENT THERAPY — ANTICOAGULANTS. *Michael Schneyer*

When thyroid hormone is given concurrently with anticoagulants, the dose of the anticoagulant required to produce a therapeutic effect must be reduced in order to avoid serious bleeding. Although the mechanism of this potentially hazardous interaction is not known, it seems that thyroxin increases the depressant effect of the coumarin type anticoagulants, on the vitamin K depending clotting factor. It has also been well documented that the presence of a myxedematous state may require increased dose of anticoagulant and a state of thyrotoxicosis may require a decreased dose. Preventive measures include monitoring of prothrombin time and thyroid function and increasing or decreasing the dose of anticoagulant as indicated.

11:00

32. DISULFIRAM (ANTABUSE) — ALCOHOL. *Eugene R. Loudon*

Disulfiram (Antabuse) in the proper dose is a safe and useful drug as a deterrent in the treatment of alcoholism. It acts by inhibiting the enzyme acetaldehyde dehydrogenase which is necessary for the normal breakdown of acetaldehyde, an intermediate product in the metabolic oxidation of alcohol. In the presence of alcohol in the body disulfiram will cause an accumulation of acetaldehyde with resulting toxic effects, including severe shocklike symptoms, flushing, tachycardia, and a pounding headache. Finally, vomiting and collapse may occur. The reaction may last from two to four hours, followed by sleep and a gradual return to normal. The clinical rate of occurrence of this reaction can be very low if all patients on disulfiram therapy are made aware of the violent reactions which will occur if they consume alcohol in any form, including cough medicine, elixirs, and foods containing alcohol. It should be recognized, however, that disulfiram alone cannot be the complete answer to such a complex behavioral disorder as alcoholism.

11:15

33. COUMARIN ANTICOAGULANTS — PHENYL-BUTAZONE (BUTAZOLIDIN). *Larry K. Westfall*

Anticoagulant drugs in use at present act by inhibiting the action or formation of one or more clotting factors. It has also been shown that these drugs are highly bound to plasma protein. Therefore, the co-administration of phenylbutazone, which also has a high affinity for binding to plasma protein, will displace the anticoagulant from its binding site, and enhance the anticoagulant effect. There are numerous reports and even death from this interaction. The interaction is *very significant* and *hazardous* and nearly all patients treated with both drugs show enhanced anticoagulant activity. Preventive measures include avoiding this combination unless *absolutely necessary* for patient welfare, or if a bleeding episode does occur, stop administration of both drugs immediately and begin therapy with menadiol sodium diphosphate.

TUESDAY AFTERNOON, May 1, 1973

Room 201 Allied Health Professions Building,
32 South Greene Street

Chairman: Robert T. Louis-Ferdinand, Ph.D.

1:30

34. ALCOHOL—BARBITURATES. *Paul J. Crist*

Barbiturates cause a non-specific depression of the central nervous system; ethanol works also to depress the central nervous system. Therefore, the concurrent use of these agents may cause an additive effect resulting in an over-depression. Both agents produce blocking of the reticular activating system in the brain stem, depression of medullary and pontine representations of respiratory control, and depression of the medullary vasomotor center. This has been shown to be the cause of a number of deaths by respiratory failure and cardiovascular collapse. In a postmortem series performed by Tom Saldeen, M.D. and Orian Johansson, M.D. (J. Forensic Sci., 12:273-294 1967) 34 cases were evaluated in which the cause of death was attributed to barbiturate-alcohol combinations. Average blood levels of alcohol (0.11 mg/100 ml) and barbiturates (2.6 mg/100 g liver) were found to be significantly lower than when either drug alone was designated as cause of death, barbiturates (5.1 mg/100 ml), alcohol (400 mg/100 ml).

1:45

35. CLOFIBRATE AND ANTICOAGULANTS. *Leonard Patras*

Clofibrate is used to reduce elevated serum lipid, cholesterol and triglyceride levels. It causes inhibition of cholesterol synthesis and increases excretion of neutral sterols. There are two mechanisms of lowering triglyceride levels: 1) by displacing thyroxine and free fatty acids from plasma albumin which leads to a decreased level of plasma free fatty acids; 2) by

inhibiting the transfer of triglycerides from liver into the plasma. Coumadin is a blood anticoagulant by inhibiting prothrombin time. The interaction is that clofibrate causes an increased affinity of the receptor site for the anticoagulants. Clofibrate noncompetitively displaced warfarin from its plasma protein-binding sites increasing the quantity of unbound or pharmacologically active drug. This effect does not happen in every person. When taking this type of therapy the patient's dose of the anticoagulant should be reduced 1/2 - 1/3 and then monitored to the wanted prothrombin time levels.

2:00

36. METHYLDOPA (ALDOMET) — PARGYLINE.
Louisa L. Chen

Methyldopa, which normally causes sedation, causes central excitation and hallucinations in patients pretreated with Pargyline, (a monoamine oxidase inhibitor) after a lag of a few hours. This excitation and other psychotic disturbances may be caused by accumulation of free catecholamines liberated by amines which are slowly formed by decarboxylation of methyldopa. Although there are few reports of adverse reactions due to a pargyline-methyldopa interaction, and indeed pargyline alone may cause hallucination, the potential danger of the interaction should not be overlooked. Preventive measure is that pargyline and methyldopa should not be combined in antihypertensive therapy.

2:15

37. DIGITALIS GLYCOSIDES AND THIAZIDE
DIURETICS. *Virginia T. Kreul*

Thiazide diuretics are often prescribed with digitalis glycosides to treat congestive heart failure. The thiazides, by inhibiting tubular reabsorption of potassium, will aggravate an already present hypokalemia produced in the myocardium by digitalis, and will predispose the patient to digitalis toxicity. Present evidence indicates that digitalis is a specific inhibitor of the $\text{Na}^+ \cdot \text{K}^+$ activated ATPase, an enzyme which liberates energy required by the Na pump. With the resulting electrolyte imbalance, the potential change necessary to achieve threshold becomes less and tachyarrhythmias result. Careful administration of potassium is one of the important treatments for digitalis induced arrhythmias. Supportive data indicates that this interaction may occur in as many as 50% of digitalized patients unless efforts are made to prevent hypokalemia. These may include substituting a K-sparing diuretic (Triamterene) for the thiazide, or administering a K-supplement along with the thiazide, or dietary supplementation with K-rich foods like bananas and orange juice.

2:30

38. ORAL CONTRACEPTIVES — ANTIDIABETIC
AGENTS. *Pamela K. Lindsay*

There are two postulated mechanisms for the alteration of glucose tolerance seen in a significant per-

centage of women taking oral contraceptives. They are 1) increased insulin binding similar to the binding of thyroxine and corticosteroids which is observed following administration of estrogen-progestin combinations and 2) an estrogen induced stimulation of ACTH secretion. Oral contraceptives may therefore cause increased insulin requirements in diabetic women. Although only one case has been reported where a woman taking oral contraceptives required greatly increased dosages of a hypoglycemic agent to control her diabetes, there is a potential for serious implications in controlling diabetes when administering oral contraceptives. There may also be potential problems in women who are predisposed to diabetes because of the binding of endogenous insulin. It is therefore necessary to carefully monitor diabetic patients taking oral contraceptives as well as to monitor patients taking oral contraceptives for signs of diabetes. Other forms of contraception should be used in diabetic patients whenever feasible to prevent this possible interaction.

2:45

39. NEOSYNEPHRINE (EYE DROPS) —
GUANETHIDINE (ISMELIN). *David Schlein*

Neosynephrine (Phenylephrine Hydrochloride) is chemically different from epinephrine in lacking an $\dots \text{OH} \dots$ in the four position of the benzene ring. Phenylephrine has direct alpha stimulating effects. It is used for its alpha effect to cause mydriasis and contraction of the radial muscle of the iris. Guanethedine depresses the function of post ganglionic adrenergic nerves. Its action is twofold. The major effect is the inhibition of responses to sympathetic adrenergic nerve activity associated with a much reduced release of norepinephrine. Guanethedine also causes sensitization of effector cells to catecholamines. The mydriatic action of phenylephrine is shown to be potentiated by guanethidine eye drops ten percent by sensitizing the effector site to catecholamines. The mydriatic action increased to obtain a maximum value after twenty eight days with chronic guanethidine administration.

3:00

40. DIPHENYLHYDANTOIN (DILANTIN) —
ISONIAZID (NYDRAZID). *Walter T. Dolan*

It is well established that therapy which mixes diphenylhydantoin and isoniazid can result in diphenylhydantoin intoxication in individuals who are "slow inactivators" of isoniazid. Isoniazid, when inactivated slowly, will inhibit the parahydroxylation of diphenylhydantoin by an unknown mechanism involving the binding up of folic acid. It is postulated that folic acid is active as a cofactor in the parahydroxylation of diphenylhydantoin. As diphenylhydantoin blood levels build in the slow inactivator of isoniazid, the first sign of intoxication is nystagmus followed by ataxia and drowsiness. This intoxication is easily reversed by reducing the dosage level of diphenylhydantoin. Reducing the dosage level of diphenylhydantoin has no appreciable effect on its anticonvulsant activity as long

as the patient continues on isoniazid therapy and diphenylhydantoin blood levels are carefully titred. Diphenylhydantoin blood levels should be maintained between 5-15 ug/ml. Folic acid (15 ug/day) will also reverse diphenylhydantoin intoxication.

3:15

41. ALLOPURINOL (ZYLORIM) —
MERCAPTOPURINE (PURINETHOL).
Linda F. Wohl

The xanthine-oxidase inhibitor allopurinol alters the catabolism of 6-mercaptopurine by a delay in its oxidation to the inactive metabolite 6-thiouric acid. This delay prolongs the retention of the free anti-purines in the body and thus the dose of mercaptopurine can be decreased lessening the possibility of toxicity and side effects. The inhibition of the oxidation of mercaptopurine also offers an increased therapeutic advantage in the treating of patients with acute leukemia the drug can remain in its active form longer and prolong its effectiveness. Since allopurinol can safely and effectively lower serum and urine uric acid levels, and because of its interaction with mercaptopurine, both of these drugs can be utilized to treat patients suffering from leukemia and gout simultaneously.

3:30

42. KAOPECTATE—LINCOCIN (LINCOMYCIN).
Janet M. Jones.

Kaopectate, a mixture of kaolin and pectin, is used medicinally as an adsorbant. It is especially useful in the treatment of diarrhea caused by bacterial toxins capable of being adsorbed. Due to this adsorption mechanism, antidiarrheal mixtures are also capable of adsorbing medications that are administered concurrently resulting in a decrease in the rate and extent of their absorption in the gastrointestinal tract. Coadministration of Kaopectate with the antibiotic Lincocin (lincomycin hydrochloride) has been shown to reduce blood levels of lincomycin to about 1/10 the levels obtained in fasting subjects. This is due to the slow dissociation rate of the Lincomycin-Kaopectate "complex" resulting in decreased amounts of lincomycin absorbed during the time the drug is within the area of the gastrointestinal tract favorable to absorption. When Kaopectate is indicated for patients on lincomycin therapy, the Kaopectate should be administered at least 2 hours before the administration of lincomycin.

3:45

43. AMITRIPTYLINE (ELAVIL) — METHYLDOPA (ALDOMET). *Louise F. Quan*

Amitriptyline exerts a cocaine-like effect characterized by the blockade of uptake of administered norepinephrine by the adrenergic neurons. This results in the supersensitization of the patient to catecholamines. Although amitriptyline does antagonize guanethidine, another antihypertensive agent, in this manner, it does not alter the hypotensive effect of

methyldopa since the mechanism of methyldopa is not the entrance into adrenergic neurons by the norepinephrine pump. Although only one case has been reported establishing an interaction between amitriptyline and methyldopa, it is advised that caution be exercised in patients with a history of susceptibility to psychotogenic reactions and also in patients of advanced age, since incidents of such interaction have been reported to include agitation, fine hand tremors and increased pulse rate and blood pressure. This is obviously contraindicated in antihypertensive therapy.

4:00

44. AMITRIPTYLINE (ELAVIL) — CHLORDIAZEPOXIDE (LIBRIUM). *Jerry L. Wilhelm*

The concurrent use of amitriptyline and chlordiazepoxide results in the potentiation of the side effects of both drugs; particularly sedation, slurred speech, and severe depression. The literature contains no mechanism for this interaction which occurs in high enough percentages of patients to be a serious problem. There are at least two reasons for this effect. One is the saturation of enzyme systems for N-demethylation resulting in an overdose of both drugs since they both undergo N-demethylation. The second mechanism is the desensitization of amino receptors by chlordiazepoxide. This drug has been shown to antagonize the effects of high doses of norepinephrine when an animal is pretreated with an MAO inhibitor followed by chlordiazepoxide and tetrabenazene. Since chlordiazepoxide has been used with no increase of side effects with MAO inhibitors, the most likely mechanism seems to be the first.

4:15

45. ANTIHYPERTENSIVES AND ANTIHISTAMINES. *David L. Bennion*

Certain antihistaminic agents can antagonize the effect of antihypertensive drugs. Both prescription and O.T.C. products that contain antihistamines can cause this action. The thiazide diuretics used commonly in the treatment of hypertension are not involved in this reaction. The adrenergic blocking action of guanethidine has been blocked by certain antihistamines. That the cardiovascular action of norepinephrine can be potentiated by antihistamines by the inhibition of the uptake of norepinephrine into the nerve can be used to explain the above interaction and point to a possible similar interaction with monoamine oxidase inhibitors used in hypertension therapy. The pharmacist is in a critical position in the prevention of this interaction.

Room 217, Allied Health Professions Building,
32 South Greene Street
Chairman: Joseph Adir, Ph.D.

1:30

46. DIAZOXIDE — THIAZIDE DIURETICS.
Adrienne K. Watson

Antihypertensives in general have quite diverse mechanisms of action. Adrenergic blocking agents, such

as rauwolfia compounds, act to decrease norepinephrine release from the postganglionic adrenergic nerves which then decrease peripheral resistance by interfering with adrenergic vasoconstriction. When rauwolfia compounds are used in combination with thiazides the antihypertensive effect is enhanced. Diazoxide in particular is thought to decrease the blood pressure due to vasodilation in the peripheral arterioles. The administration of diazoxide with thiazides can cause hyperglycemia, hyperuricemia, and the enhancement of antihypertensive effects. Thiazide diuretics produce their effect by inducing sodium diuresis and depletion of fluid volume. Even though intravenous administration of diazoxide has caused no clinical problems, sodium and water retention after repeated injections can be serious. Concurrent administration of diuretic therapy is desirable. Other diuretics that are particularly useful are Lasix and Edecrin.

1:45

47. PROPOXEPHENE (DARVON) — ORPHENADRINE (NORFLEX).

John F. Bender

Although the manufacturers of both Darvon and Norflex include the contraindication against the concomitant use of these two drugs, there is virtually no substantiation of this interaction in the literature. Seven unpublished reports to the manufacturers of Orphenadrine and Propoxephene (over a 14 year span) plus one undocumented case history in the "Letters to the Editor" section of a medical journal represent the total literature on this reported interaction to date. The interaction which has been described amounts to side effects common to both drugs and may be due to a simple additive effect on the CNS.

2:00

48. CHLORAMPHENICOL (CHLOROMYCETIN) — TOLBUTAMIDE (ORINASE).

Nagla A. Wahab

Chloramphenicol potentiates the effect of tolbutamide by increasing the serum levels and the half life of elimination of the unchanged tolbutamide, and consequently severe hypoglycemia may occur. Inhibition of the metabolism of tolbutamide by chloramphenicol through the inhibition of the liver metabolizing enzymes was speculated by Christensen and his associates to be the mechanism of this interaction. Chloramphenicol has also been shown to have similar effects on chlorpropamide. Metabolism of chlorpropamide was not documented until recently, when Taylor showed that up to 80% of orally administered chlorpropamide is metabolized and the remainder of the dose is excreted unchanged in urine. This may very well support the common mechanism by which chloramphenicol increases the half life of both chlorpropamide and tolbutamide. A case of chloramphenicol induced hypoglycemic coma was reported in the literature. The hypoglycemia is reversible upon withdrawing chloram-

phenicol and administration of glucose I.V. infusion. Other antibiotics may have similar effect as chloramphenicol. When chloramphenicol has to be given to patients receiving tolbutamide, chlorpropamide and other related hypoglycemic drugs, great caution must be exercised and adjustments of the dose of these drugs is always necessary.

2:15

49. COUMARIN ANTICOAGULANTS — ORAL CONTRACEPTIVES. *Joseph L. Pollard*

Use of oral contraceptives causes an induction of many of the blood coagulation factors, the greatest occurring in the Vitamin K dependent factors. These changes would be expected to be associated with increased coagulation activity of the blood, reflected in increased Prothrombin times. Withdrawal of the drug results in a return to normal levels of clotting factors. The coumarin drugs produce their anticoagulant effects by inhibiting the synthesis and thus reducing the circulation blood levels of several of the clotting factors, reflected in decreased Prothrombin times. The metabolism of the anticoagulant is unaffected. Clinical studies of combined therapy show a reduced response to coumarin anticoagulants. Desired results can be reached with increased anticoagulant levels. Since oral contraceptive use is on an intermittent basis, the combination will cause erratic anticoagulant control. Preferably patients on oral contraceptives should be converted to an alternate contraceptive method if anticoagulant therapy is needed.

2:30

50. NITROGLYCERIN — ALCOHOL.

Hal J. Weinstock

Nitroglycerin taken for angina pectoris probably works by improving myocardial function without reducing cardiac work. This is by peripheral arteriolar vasodilation resulting in a smaller left ventricular residual volume and lower filling pressure. These changes result in lower myocardial oxygen requirements and a lower transmural pressure gradient during diastole. Alcohol in moderate doses causes cutaneous vasodilation producing a warm and flushed skin due to a central vasomotor depression. In cardiac patients alcohol produces an increase in the left ventricular end-diastolic pressure, the peripheral resistance generally rises, and skeletal muscle blood flow in the limbs is always reduced. Therefore, since alcohol acts as a myocardial depressant, especially in left ventricular disease, and nitroglycerin is hypotensive, alcoholic beverages should be taken with caution in cardiac disease.

2:45

51. IMIPRAMINE (TOFRANIL) — MAO INHIBITORS. *Richard W. Pollhammer*

Monoamine oxidase functions to break down catecholamines. When inhibited, increased levels of norepinephrine within adrenergic neurons results, and

production is continued without the usual rate of destruction. These greater than usual amounts of norepinephrine, if released, can bring about exaggerated responses. Imipramine in its actions is thought to sensitize adrenergic receptors to norepinephrine, amplifying even greater the effects of its overproduction. Numerous toxic reactions including hyperpyrexia, confusion, disorientation, severe convulsive seizures, coma and death have been reported. Concomitant use should be avoided and when substitution is desired, as long an interval as therapy will allow, or at least a minimum of fourteen days, should elapse to insure safe and successful treatment. For relief of symptoms of depression, the tricyclic antidepressants such as imipramine, are replacing the MAO inhibitors as they are generally safer and more effective.

3:00

52. CHLORAL HYDRATE (NOCTEC) — ETHYL ALCOHOL. *Peter Ritterstein*

Chloral hydrate is a sedative hypnotic, which depresses CNS. Ethanol is also a CNS depressant. It depresses the reticular activating system. These two drugs have additive effect on CNS. The interaction of these drugs is due to increased rate of chloral hydrate reduction to trichloroethanol by Ethanol via alcohol dehydrogenase. The oxydation of ethyl alcohol by alcohol dehydrogenase occurs by a mechanism whereby ethly alcohol cannot combine directly with the enzyme, but does so only with a complex of the enzyme nicotinamide adenine dinucleotide. The ethanol is then oxidized to acetaldehyde while enzyme-NAD⁺ complex is reduced to an enzyme-NADH complex and it is the dissociation of the latter which is the rate controlling step of reaction. Chloral hydrate then probably combines with the enzyme-NADH complex. Chloral hydrate then in the process of being reduced to trichloroethanol gives rise to enzyme-NAD⁺ complex. Trichloroethanol is thought to be more potent than chloral hydrate itself and that is why we get potentiation. The interaction is very serious and is known as knockout drops (Mickey Finn). Ethanol should never be given with chloral hydrate.

3:15

53. ANTIHISTAMINES — MAO INHIBITORS. *Joseph E. Parker*

Certain antihistamines are contraindicated in patients taking MAO inhibitors. The resultant interaction of the effects of the two drugs can be a norepinephrine toxicity crisis. The two types of drugs work through different mechanisms that combine in effect to cause a potentially dangerous reaction. Antihistamine works at the nerve endplate to prevent the uptake of norepinephrine. Combined MAO inhibition and antihistamine blockage of uptake leads to greatly abnormal increase in free endogenous norepinephrine. Stimulation of a nerve under these conditions will result in norepinephrine being released in greater than normal quantity and in norepinephrine remaining

available to stimulate the receptors for a greater than normal length of time. The interaction is furthered by the side effect of hepatic enzyme slowing by MAO inhibitors because antihistamines are largely metabolized by the liver.

3:30

54. DIPHENYLHYDANTOIN (DILANTIN) — PHENOBARBITAL. *Jay R. Newirth*

Phenobarbital (and other closely related barbiturates) have both an inductive and inhibitory effect on the hepatic microsomal enzyme system responsible for drug metabolism resulting in fluctuating blood levels of co-administered drugs as seen with antiepileptic agents such as diphenylhydantoin (DPH) and other closely related hydantoin. Studies in both humans and dogs show definite changes in DPH blood plasma levels and plasma $t_{1/2}$ with no loss of anticonvulsive activity. Up to now, no clinical significance has been ascertained to the potential interaction between the two drugs and no toxic effects or loss of epileptical control (of such patients) by DPH has been observed. As a result, withdrawal from concomitant usage of DPH and phenobarbital is not necessary. A possible interaction may occur in treatment of cardiac arrhythmia with IV administration of DPH with phenobarbital producing uncontrolled arrhythmic conditions along with toxic levels of DPH.

3:45

55. METHYLPHENIDATE (RITALIN) — ANTICOAGULANTS. *Walter J. Hryszko*

Methylphenidate (Ritalin^R) has been postulated to inhibit hepatic hydroxylating enzymes therefore potentiating the effect of drugs which are hydroxylated in the liver to an inactive form. Some anticoagulants are metabolized in the liver to an inactive hydroxy metabolite; if hepatic hydroxylating enzymes are inhibited, this type of anticoagulant will be potentiated. Although there are conflicting reports of severe interactions at therapeutic doses, the possibility of this reaction exists. Any physician prescribing these two drugs should be made aware of the possibility of this interaction.

4:00

56. HEPARIN AND ALL BASIC DRUGS. *Michael S. Luger*

The effects of heparin relate to its ability to prevent the conversion of prothrombin to thrombin thus preventing coagulation. As heparin is the most acidic molecule in the body, any strong base or positively charged molecule has the ability to covalently bind to the heparin thus interfering with its actions. Many compounds have been proposed to interfere with heparin either in vivo or in vitro. With the majority of these drugs the problems encountered are probably more significant in vitro than in vivo. The most recent articles are indicating that at therapeutic doses nor

mally used many of these drugs show no incompatibility. Thus far, only a few drugs have been shown to be incompatible with heparin. These drugs are: protamine, aminoguanidine, toluidine blue, and polybrene on a one to one basis and d-tubo curarine when heparin is used in high doses. With the compounds listed above the competition can be expected to be seen in one hundred percent of cases. There is a study currently under way in Canada which is concerned with the in vivo interaction of many basic drugs with heparin.

4:15

57. SALICYLATES—PROBENECID (BENEMID).

Robert P. Zepp

The interaction between salicylates and probenecid is dose related. Probenecid uricosuria can be antagonized by low doses of salicylates by blocking probenecid secretion into the renal tubules where it prevents reabsorption of uric acid. However, low doses of salicylates have no influence on inhibiting penicillin secretion produced by probenecid. There has been no constant finding to indicate whether uricosuric doses of salicylates and probenecid have additive results when administered together. Preventive measures include use of a substitute drug which is equally effective in controlling pain, fever, or inflammation but has no effect on uric acid clearance.

Health Sciences Library Auditorium

Chairman: David A. Blake, Ph.D.

1:30

58. PROMAZINE AND MEPERIDINE.

Katherine A. Montalbano

The interaction between Promazine (Sparine) and Meperidine (Demerol) is one of potentiation of the hypnotic and analgesic effects of Meperidine by Promazine. This potentiation can be beneficial, if carefully monitored, and can be especially useful when used during childbirth. This combination provides for a small requirement for both analgesics and anesthesia and also affords a better degree of analgesia and relaxation during labor than other combinations in use.

1:45

59. HYDROCORTISONE (CORTEF)—TRICYCLIC ANTIDEPRESSANTS. *Robert R. Foreman*

Hydrocortisone is an endogenous anti-inflammatory steroid hormone secreted by the adrenal cortex and oxidatively metabolized in the presence of NADPH and oxygen by the mixed function oxidase system found in the microsomal fraction of the liver. Tricyclic antidepressants are metabolized in vivo by N-demethylation and hydroxylation by the same microsomal mixed function oxidase system. When administered concomitantly, hydrocortisone inhibits the metabolic breakdown and excretion of nortriptyline and other tricyclic antidepressants via substrate inhibition and thus potentiates the action of these drug products. Preventive measures include decreasing the dose of the tricyclic antidepressant or decreasing the frequency of the dose.

2:00

60. CHOLESTYRAMINE AND ORALLY ABSORBED DRUGS. *Russell Gobeille*

Cholestyramine is a basic anion exchange resin consisting of quarternary ammonium groups attached to a styrene 2% divinyl benzene skeleton. It is used for the relief of pruritis associated with partial biliary obstruction. The mechanism of action involves binding of bile acids and thus preventing their reabsorption into the entero-hepatic circulation. However, this binding is not specific for bile acids, and at least five other compounds have exhibited this tendency. For three of them, anticoagulants (Warfarin), Phenylbutazone, and thiazide diuretics the data is insufficient to evaluate the potential clinical significance. The remaining two compounds, thyroxine and triiodothyronine, have been definitely shown to be bound by cholestyramine to the extent that significant reductions in absorption occur. This problem can be alleviated by allowing 4-5 hours to elapse between administering the hormones and the cholestyramine.

2:15

61. DIPHENYLHYDANTOIN (DILANTIN) — DEXAMETHASONE-METYPAPONE.

Thomas E. Donohue

Recognized studies showing the effects of DPH on the microsomal hepatic enzymes have clearly shown that DPH is a powerful inducer of these enzymes. Dexamethasone is metabolized in the liver. It is probably that DPH enhances the metabolism of Dexamethasone due to the above mentioned enzyme induction, however, the magnitude of this inhibition remains to be established. Metyrapone has the immediate effect of reducing cortisol production by inhibition of adrenal 11 Beta hydroxylation with a resultant increase in ACTH. However, in the epileptic receiving DPH, there has been observed an inadequate response to metyrapone. One explanation may be that hepatic clearance of metyrapone is hastened due to enzyme induction by DPH. This would prevent sufficient concentration of metyrapone from reaching the adrenal cortex. The inducing effect of DPH may also be seen with Triamcinolone and other corticosteroids. The frequency of occurrence of these interactions is so high that interpretation of dexamethasone suppression tests and pituitary responsiveness by metyrapone tests is open to question in patients receiving DPH.

2:30

62. GUANETHIDINE (ISMELIN) — ANOREXICS (Amphetamines and related sympathomimetic amines). *Ralph A. Small, Jr.*

Norepinephrine acts predominantly on alpha-adrenergic receptors to cause vasoconstriction, resulting in hypertension. The hypertensive lowering effect of guanethidine, an adrenergic neuron blocking agent, occurs when the storage, release, or binding of norepinephrine is interfered with. The anti-hypertensive effect of guanethidine is antagonized by dexa-

phetamine and other related sympathomimetic amines. These drugs prevent or reverse the adrenergic blocking activity of guanethidine. This is accomplished by displacement of guanethidine from adrenergic neurons and inhibition of its uptake by these neurons. Consequently, patients on concurrent guanethidine-sympathomimetic amine therapy show a higher than desired blood pressure. Several cases have been described for the interaction of patients on both guanethidine and amphetamine. Interactions for guanethidine and the other sympathomimetic agents have been pointed out in animal studies. Because hypertensive control in these cases has been substantially interfered with, the interaction is significant. After all, it is not unusual for physicians to place their patients on diets to reduce weight. To prevent the interaction, it should be contraindicated to prescribe or administer amphetamines and other related sympathomimetic amines to patients taking guanethidine. However, amphetamines can be used as an antidote in those patients in which the guanethidine has lowered the blood pressure to dangerous levels.

2:45

63. THYROID REPLACEMENT THERAPY AND DIGITALIS GLYCOSIDES. *Tom S. Petr*

Thyroid hormone appears to exert an effect on just about every organ and tissue of the body; it increases the metabolic rate of the whole organism with only certain tissues being affected. One of the primary actions of the hormone is to promote the synthesis of protein. When Digitalis glycosides are administered concurrently to patients receiving thyroid replacement therapy, there is a decrease in the effectiveness of digitalis which was attributed to the phase of tissue distribution and binding of the glycoside. Although there needs to be more evidence on the exact mechanism of action in the changes that take place in tissue binding of digitalis, there is considerable supportive data that the effects of digitalis are reduced during thyroid replacement therapy and the interaction is clinically significant and potentially serious. Rauwolfia alkaloids such as reserpine and syrosingopine are preventive measures in that they decrease the digitalis requirements and therefore eliminate the need for large doses of digitalis during thyroid replacement therapy.

3:00

64. ANTIBIOTICS — BISHYDROXYCOUMARIN (DICUMAROL). *Marta M. Procinsky*

Antibiotics in particular inhibit the synthesis of Vitamin K by intestinal micro-organisms. Dicumarol is thought to function as an antimetabolite that competes with the natural metabolite, Vitamin K, in an enzyme system that is responsible for the synthesis of clotting factors II (prothrombin), VII, IX, and X. The response of the antibiotics' effect on Dicumarol is often called the "prothrombinopenic" or "hypoprothrombinemic response" (i.e. prolonged prothrombin time), which has been supported by animal experi-

mental studies. Therefore, antibiotics enhance the action of Dicumarol, with the possibility that the anti-coagulant treatment may become either ineffective or dangerous. In recent years, much evidence for the alteration of the anticoagulant activity of oral coumarins by interacting antibiotics has appeared in the literature. Therefore, the treatment of each patient with Dicumarol is a highly individualized matter and dosage of the anticoagulant can be determined only by periodic monitoring of the prothrombin time.

3:15

65. ETHACRYNIC ACID (EDECRIN) KANAMYCIN (KANTREX). *Regina M. Fletcher*

Ethacrynic acid has shown ototoxic properties thought to be due to depression of cochlear microphonic potentials and deterioration of outer hair cells. Permanent loss of hearing has been reported after intravenous administration of the drug. The aminoglycoside antibiotics, particularly kanamycin, although unrelated in structure to ethacrynic acid have shown the same ototoxic effects. Renal failure tremendously increases the possibility of ototoxicity from kanamycin therapy. When used concomitantly, ethacrynic acid and kanamycin display an effect that is likely additive or synergistic. Kanamycin and the other aminoglycoside antibiotics, should be used cautiously, if at all, in renal failure. Therapy should be discontinued at the first sign of hearing impairment. Ethacrynic acid should be replaced with another diuretic if kanamycin therapy must be initiated. Furosemide, which has some ototoxic properties, should be used cautiously as an ethacrynic acid substitute until further data establishes its safety in this area.

3:30

66. DIPHENYLHYDANTOIN (DILANTIN) — ALCOHOL. *Cleveland K. Yee*

Diphenylhydantoin is indicated for control of grand-mal and psychomotor seizures and for the symptomatic relief of vascular headaches i.e. migraine and trigeminal neuralgia. The ultimate metabolic disposal of the diphenylhydantoin has been shown in rats and humans to be in the liver. The liver is the chief site of detoxification with only two percent of the free drug found in the bile which is reabsorbed when released in the gastrointestinal tract. Consumption of alcohol along with the diphenylhydantoin causes an increase in microsomal enzymes therefore the rate of detoxification of the drug is increased and thus decreasing the half life of the drug and the action of the drug by increasing the rate of excretion. Consequently, plasma levels are lowered below the therapeutic level, which may interfere with the action of diphenylhydantoin.

3:45

67. INSULIN — HYDROCHLOROTHIAZIDE (HYDRODIURIL). *Sherry R. Norwitz*

Thiazide diuretics have various influences on the blood glucose level of insulin controlled diabetics. In-

sulin requirements may be decreased or unchanged, but in most instances they are increased. The mechanism of this reaction has not yet been defined. Theories proposed for the cause of thiazide induced hyperglycemia include potassium ion loss due to the diuretic and increased gluconeogenesis associated with increased adrenal function after the use of thiazides. Insulin controlled diabetics on thiazide therapy should be watched for possible decreased diabetic control. Successful control has included administration of substantial doses of potassium, adjustment of insulin dose, or the use of a less diabetogenic diuretic such as triamterene, ethacrynic acid, or furosemide.

4:00

68. L-DIHYDROXYPHENYLALANINE (DOPA)—
MONOAMINE OXIDASE INHIBITOR.

Francis Eng

L-Dopa when orally administered to patients with the monoamine oxidase inhibitor can cause a transitory elevation of blood pressure. The concentration of "plasma catecholamine" (norepinephrine, dopamine and epinephrine) was elevated following dopa administration in patients pretreated with a MAO inhibitor. The combination of pargyline and dopa have been used in the treatment of patients with depressive manifestation. The improvement in mood and self-confidence resembled that obtainable with amphetamine, but lasted longer. The favorable aspects are overshadowed by the hazards with this combination so therefore should be administered under very close monitoring.

Obituaries

Lawrence G. Heller

Lawrence G. Heller, 70, died on March 2. He graduated from the Pittsburgh College of Pharmacy in 1926 and became licensed by reciprocity in Maryland in 1947.

Dr. Archie R. Cohen

Dr. Archie R. Cohen, 66, a 1926 graduate of the University of Maryland, School of Pharmacy and 1930 graduate of the School of Medicine, died on March 7.

Dr. Joseph Lipskey

Dr. Joseph Lipskey, 81, died on March 12. He graduated from the University of Maryland, School of Pharmacy in 1926 and from the School of Medicine in 1930.

Dr. Milton B. Kress

Dr. Milton B. Kress, died at the age of 64. He was a 1928 graduate of the University of Maryland, School of Pharmacy and a 1932 graduate of the School of Medicine.

PHARMACY CALENDAR

May 10 (Thursday) — Maryland Society of Hospital Pharmacists meeting at St. Joseph's Hospital, Towson.

May 15 (Tuesday)—Annual Business Meeting and Election of Officers, School of Pharmacy Alumni Association, Baltimore Student Union, 7:30 p.m.

May 15 - 21—Maryland Pharmaceutical Association. Fiesta in Spain. Convention and tour.

May 30 (Wednesday)—47th Annual Graduation Banquet, School of Pharmacy Alumni Association, Martin's Eudowood Gardens, 6:00 p.m.

June 15 - 17—Eighth Annual Hospital Pharmacy Seminar—Maryland Society of Hospital Pharmacists, Diplomat Motel, Ocean City, Maryland.

June 24 (Sunday)—A.Z.O. Installation Banquet, Hunt Valley Inn, Cockeysville, 6:00 p.m.

June 29 - July 1—91st Annual Convention, Maryland Pharmaceutical Association. Hunt Valley Inn, near Baltimore.

July 21-27—American Pharmaceutical Association Annual Meeting, Boston, Massachusetts.

December 9 - 13—American Society of Hospital Pharmacists Midyear Clinical Meeting, New Orleans, Louisiana.

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VD prevention news

10 MILLIONTH "PLAIN TALK" V.D. PAMPHLET DISTRIBUTED

With V.D. on the climb throughout the world, it's comforting to note that the public is really getting the word on how to aid in its prevention. To date, Youngs



Here Mel Clark (left) Sales Manager, Youngs Drug Products Corp., presents 10 Millionth Pamphlet entitled "Plain Talk About V.D." to Virginia Governor Linwood Holton on the occasion of State's special "V.D. Awareness Month." Looking on are Thomas W. Rorer, President VPhA and Richard B. Lake, Chairman of Public Affairs Commission.

has printed and distributed over 10 million copies of the informative booklet entitled "Plain Talk About V.D."

ANOTHER YOUNGS ADVERTISING FIRST

In 1968 Youngs Drug Products Corporation created history as a prophylactic company by pioneering the first condom ad ever to run in a consumer magazine. And now they've done it again! In late 1972 and 1973

Youngs is sponsoring the first condom radio commercials ever to be aired in the U.S. A saturation program starting with a series of three, thirty-second prime drive time spots will be run on Black radio station WNJR. WNJR's New York and New Jersey market represents an audience of 1 3/4 million listeners to make up a lucrative market of over one billion

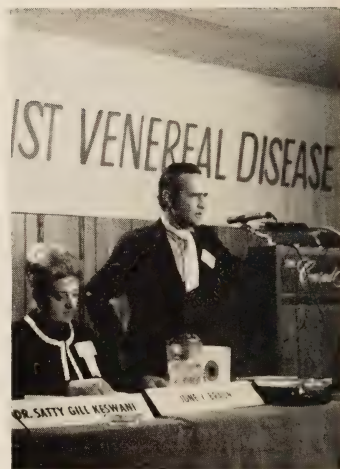


dollars annually. The cleverly written radio dialogue drives home the point that listeners should visit their pharmacist and ask for TROJANS, the number one drug-store brand.

NATIONWIDE "WOMAN'S WAR" WAGED AGAINST V.D.

Nearly 500 women members of WONARD (Women's Organization of NARD) convened in Chicago at the NARD Convention to organize a War on Venereal Disease. The new WONARD campaign will stress PREVENTION as the single, most important method to combat the nation's most serious

epidemic illness. Guest speakers at the V.D. symposium included Frank Santora, Chief of V.D. Information, New York City Department of Public Health, Dr. Satty Gill Keswani, India-born gynecologist and a specialist in the problem of infertility, Stephanie D. Radford, registered pharmacist from Washington State, and John C. MacFarlane (pictured above) president of Youngs Drug Products Corporation.



The importance of the meeting was attested by the fact that the three major TV news networks, ABC, CBS, and NBC covered the proceedings along with local Chicago TV and newspapers. One of the revealing facts that came up at the convention was that the nation's 130,000 pharmacists now comprise the most active organized bloc fighting venereal disease.

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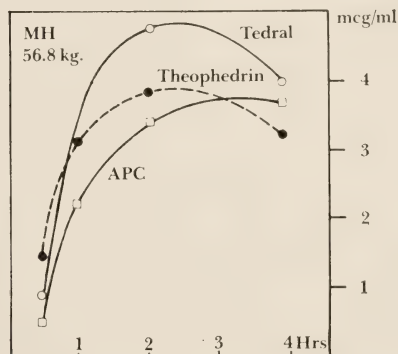
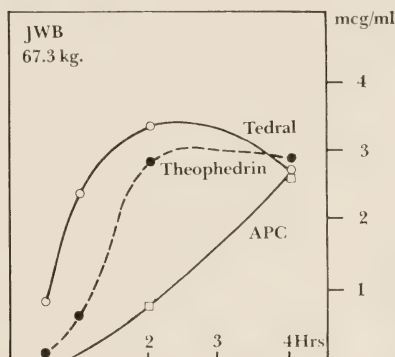


MS-GP-30

1. Lach, J. L., Chin, T. and Parrott, E. L.:
Variations in Theophylline, Ephedrine
Hydrochloride and Phenobarbital Tablets
Manufactured by Thirteen Firms, to be
published. 2. Bettis, J. W., Lach, J. L. and
Hood, F.: Effect of Complexation Upon the
Biologic Availability of Theophylline,

Blood Level Comparison: Tedral* vs Two Generic T-E-P's

Bettis and associates² found higher
blood levels of theophylline from
Tedral than from two formulary
alternates in 6 of 9 subjects

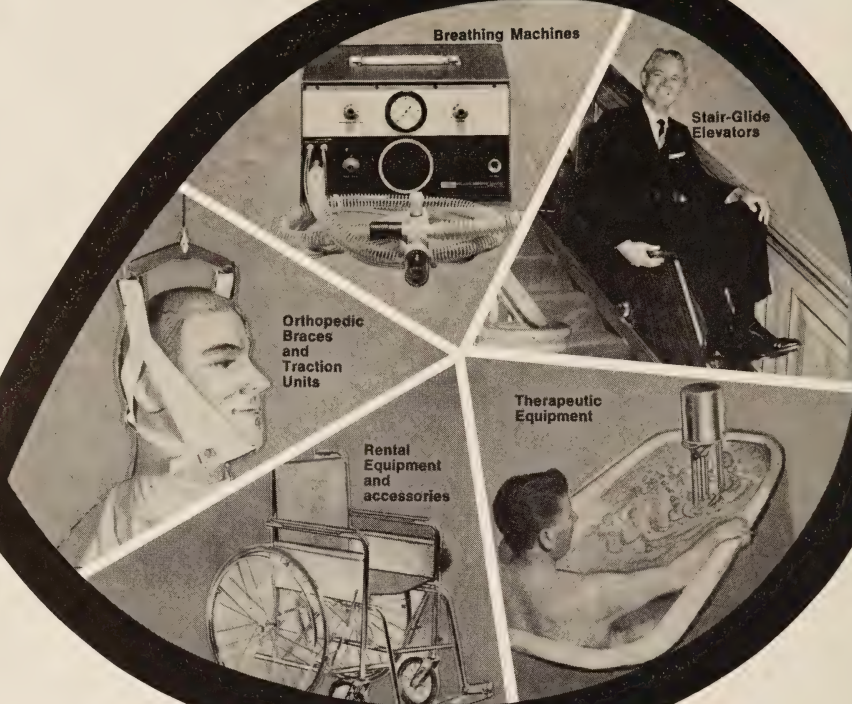


They concluded that the differences between Tedral and the two alternates could be due to differences in the extent of interaction between theophylline and phenobarbital during manufacture. (The USP and NF do not specify methods of manufacture to be used for T-E-P drugs.) As a result of this study, the use of substitutes for Tedral was discontinued at this university hospital.

*Each tablet contains 130 mg theophylline, 24 mg ephedrine HCl, and 8 mg phenobarbital.

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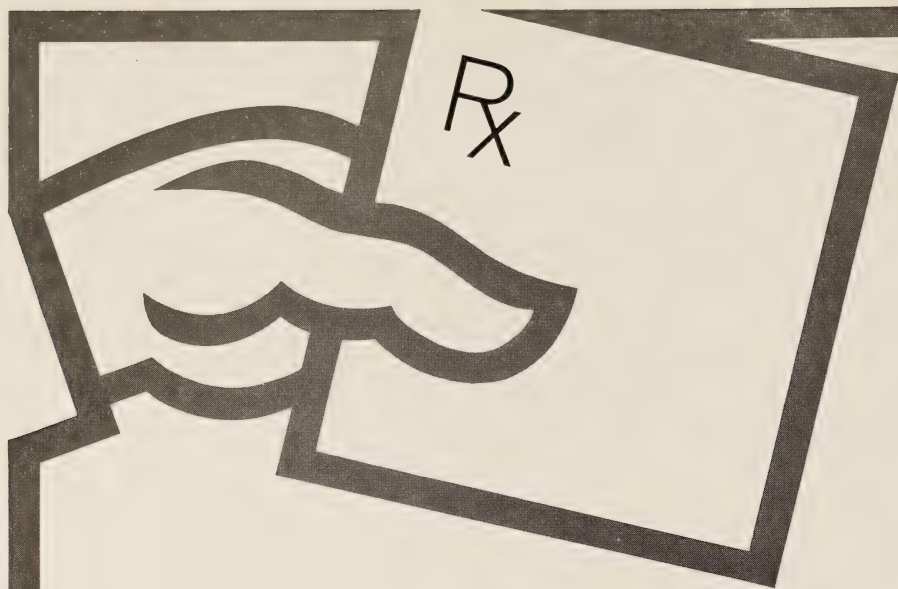


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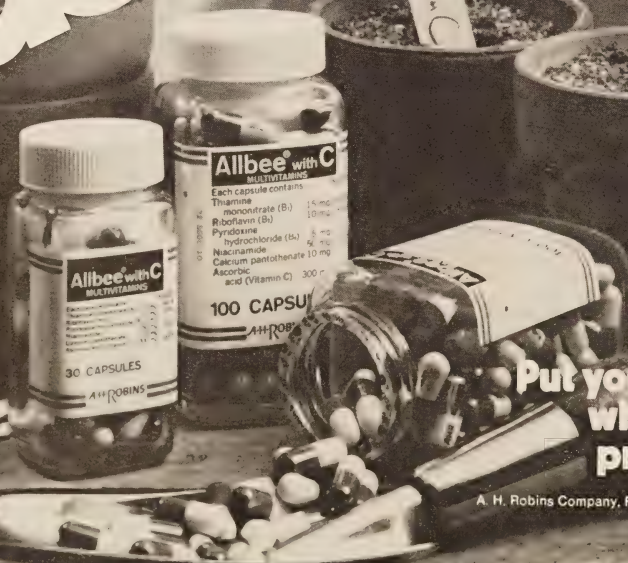
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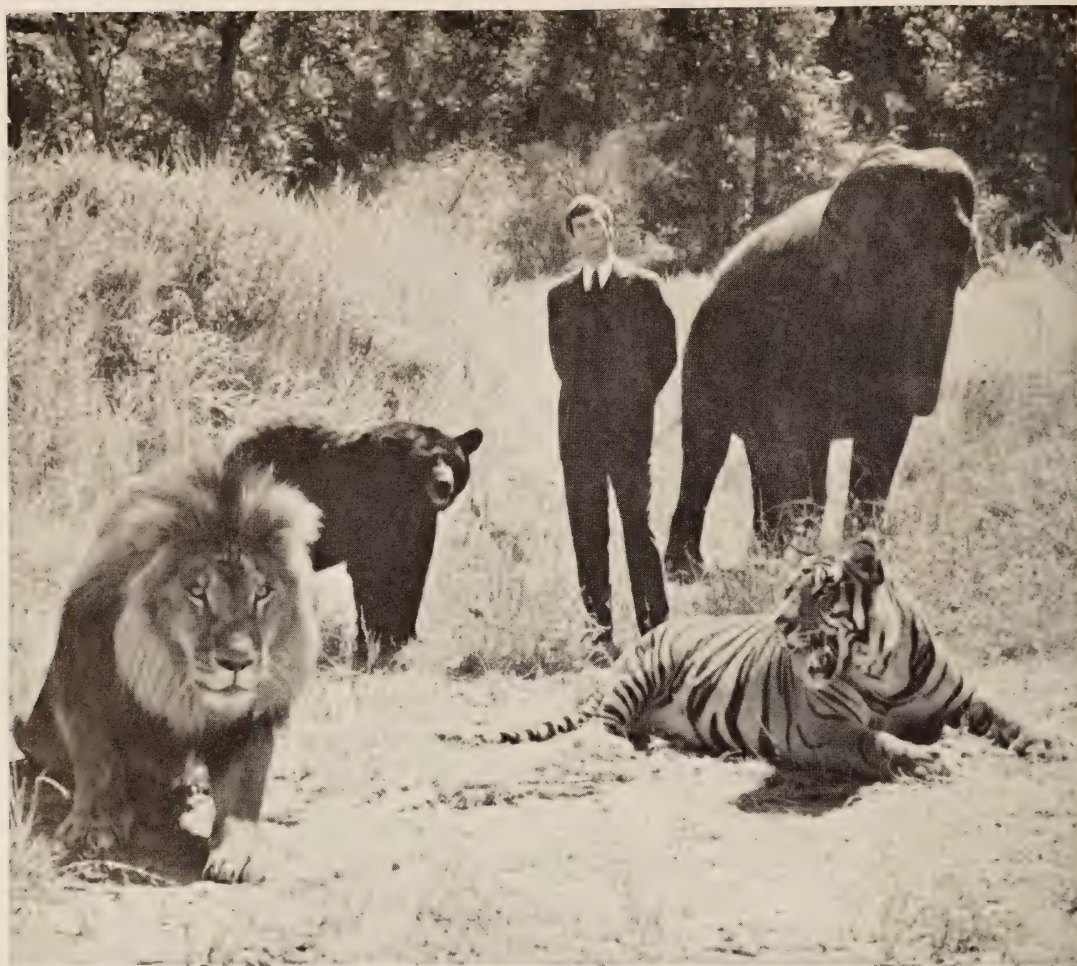
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the maryland pharmacist

APRIL
1973
Volume 49
Number 4

Annual Report

Maryland Board of Pharmacy

Annual Convention

MPhA - TAMPA - LAMPA

June 29, 30, July 1

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The Maryland Pharmacist

NATHAN I. GRUZ, *Editor*
NORMAND A. PELISSIER, *Assistant Editor*
ROSS P. CAMPBELL, *News Correspondent*
HERMAN J. BLOOM, *Photographer*

650 WEST LOMBARD STREET
BALTIMORE, MARYLAND 21201
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APRIL 1973

NUMBER 4

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Editorial . . .

Yes, Pharmacists Save Lives!

Pharmacists and their professional associations — local, state, and national—have been engaged in an infinite number and variety of activities “to promote a better image of pharmacists and pharmacy.”

We have National Pharmacy Week. We have involvement in Poison Prevention Week, Diabetic Detection Week, and numerous health and civic programs. All these projects are important and worthy of our continuing attention and support.

However, there is one critical area upon which no one but pharmacists and their organizations can be expected to concentrate. Only pharmacists and their professional associations can be expected to give overwhelming priority in time, staff, and funds to the telling of the story of the vital role of the pharmacist in truly effective comprehensive health care of the patient.

Here is what we must do if pharmacy is to have a chance for survival as an independent health profession.

First, we must practice patient-oriented pharmacy. This means being available to patients coming into pharmacies. It means calling them on the telephone whenever necessary to clarify a matter concerning pharmaceutical services that involve either prescription or non-prescription medication. It means engaging in lifelong continuing education to assure current knowledge and professional competency in light of scientific and professional developments. It means becoming the real medication expert of the health team for both prescribers and patients.

Second, pharmaceutical organizations at all levels, must make the public aware that it is these patient-oriented functions and services of the pharmacist that are essential in total health care. It is these services — taken for granted all too long by the public—which safeguard the patient from the prescribing errors of physicians, from drug interactions, drug allergies, misuse of drugs, abuse of drugs, over-utilization and under-utilization.

The Maryland Pharmaceutical Association, therefore, is granting first priority in the area of public health information and public relations to just this issue — the indispensable role of the pharmacist in serving and protecting the public. As the Talmud said centuries ago, “He who saves even *one* life, it is as though he saved the world.”

Yes, it is time the public knew that pharmacists every day preserve health and save lives!

—NATHAN I. GRUZ

Maryland Board of Pharmacy News

— NOTICE —

The Maryland Board of Pharmacy will conduct an examination for registration as Pharmacist at the School of Pharmacy, University of Maryland, 636 West Lombard Street, Baltimore, Maryland.

On Tuesday, Wednesday and Thursday,
June 19, 20 and 21, 1973.

The examination will begin at 8:00 a.m. each day. Applications must be in the hands of the Board by Friday, June 8, 1973.

Pharmacy Changes

The following are the pharmacy changes for the month of March.

New Pharmacies

Powell Pharmacy, Charles A. Powell, Pres.; 10840 Little Patuxent Parkway, Columbia, Maryland 21044.

No Longer Operating As Pharmacies

Beitler's Pharmacy, Ben Beitler; 423 East Patapsco Avenue, Baltimore, Maryland 21225.

Burris & Kemp Pharmacy, Joseph Loetell, Jr., Pres.; 1600 East 32nd Street, Baltimore, Maryland 21218.

Changes of Ownership, Address

None.

PHARMACY CALENDAR

June 15 - 17—Eighth Annual Hospital Pharmacy Seminar—Maryland Society of Hospital Pharmacists, Diplomat Motel, Ocean City, Maryland.

June 24 (Sunday)—A.Z.O. Installation Banquet, Hunt Valley Inn, Cockeysville, 6:00 p.m.

June 29 - July 1—91st Annual Convention, Maryland Pharmaceutical Association, Hunt Valley Inn, near Baltimore.

July 21-27—American Pharmaceutical Association Annual Meeting, Boston, Massachusetts.

December 9 - 13—American Society of Hospital Pharmacists Midyear Clinical Meeting, New Orleans, Louisiana.

Reserve dates . . .

ANNUAL CONVENTION

MPhA - TAMPA - LAMPA

June 29, 30, July 1

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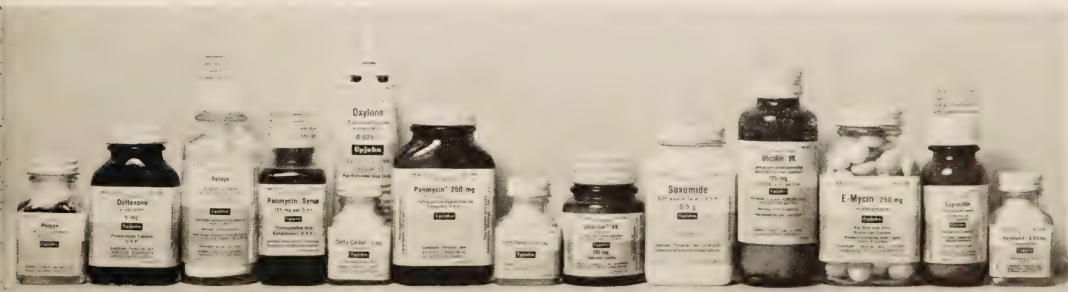
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MPhA In Action

Board of Trustees Meetings

NATHAN I. GRUZ, *Executive Director*

February 8, 1973

The following is a summary of actions taken at the February 8, 1973 meeting of the Board of Trustees:

- Noted receipt of letters from Delegates Maurer and Murphy and Senator Steers in reply to Executive Director's letter which included a first day of issue cachet of the Pharmacy stamp. First day covers were sent to the Governor and all legislators.
- Accepted President's report noting his testimony presented regarding Senator Steer's Senate Bill 155 on advertising. The President also commented on problems associated with nursing home pharmacy services, Medicaid and the generic drug bill.
- Approved Treasurer's report.
- The Executive Director reported on legislative activities. Testimony was presented on the prescription advertising bill, fair trade and HMO's. Also involvement in the bill to reduce the University of Maryland autonomy. Conferences were held with: Mr. John Kenny, the newly-appointed Director of Professional Services for Read's; meeting on health legislation with medical and allied health professionals; NAC regarding a special plan for members; continuing education; poison prevention; venereal disease; Planned Parenthood; proposed pharmacy in College Park Health Center; Board of Pharmacy; Maryland Health Maintenance Committee; Pharmaceutical Services Foundation (which plans to appoint a part-time executive director and has set up committees and plans a pilot computer run); and F. S. Balassone Memorial Committee. Several meetings were also held in connection with the Baltimore Metropolitan Pharmaceutical Association. The Executive Director was also invited to the New Jersey Pharmaceutical Association to speak on the Pharmaceutical Services Foundation of Maryland. Other major activities involved Medicaid and other third party payment programs. The Hospital Pharmacy Liaison Committee of MPhA was scheduled to meet with the Commission on Goals of the Maryland Society of Hospital Pharmacists headed by Dr. Peter P. Lamy.
- Received report from Dr. Sheila West on her participation in the VD Seminar in Houston where she also served as a representative of the Maryland Pharmaceutical Association. Dr. West spoke on the coming observance of VD Awareness Month in April and outlined in detail an MPhA program for the involvement of pharmacists on a broad scale. The matter was referred to the Professional Affairs Committee.
- Heard School of Pharmacy report. The Dean noted the adverse effects of President Nixon's budget cuts. Eleven per cent of the School of Pharmacy's budget

would be affected with the drug information program being terminated. The naming of a Hall in honor of Francis S. Balassone was approved by the University Board of Regents. In reference to a possible pharmacy in the College Park Health Center, the Dean stated that the present drug distribution system at the Center was poor with the future uncertain and in turmoil. He suggested that pharmacists in the area form a co-operative group to serve the University students and others on the campus.

- Received Board of Pharmacy report. The Board has filed an appeal of the Judge Carter decision on the Sav-A-Lot case. A bill to increase the fees for pharmacists' licenses and renewals and pharmacy permits has been introduced. Other board activities involved the Maryland Society of Hospital Pharmacists, nursing homes and hospitals.
- Endorsed in principle a proposal of the Board of Pharmacy for manufacturers and distributors of controlled dangerous substances in Maryland to notify the State Health Department of their sales.
- Discussed the critical matter of hold-ups in the pharmacies to obtain narcotics and other controlled dangerous substances.
- Agreed to seek a conference with government and police officials regarding the security problem in pharmacies.
- Approved Convention and Regional Meeting Committee report noting that the Spring Regional Meeting would be held on April 26 at Friendship International Hotel. In regards to the Convention, the banquet would be held Sunday evening with a possible theater night on Friday. It was agreed by the Board that fees would be charged for all sessions and meetings at the Convention.
- Heard House Speaker's report noting that committees of the House were functioning. Speaker Seidman also announced that the Continuing Education Program on Clinical Biochemistry would begin on March 6 in the Francis S. Balassone Hall. He thanked the editor for the full page on continuing education in *The Maryland Pharmacist*.
- Noted that the Committee on Revision of the U.S.P. had discussed the possibility of a U.S.P.—N.F. combined compendium. The U.S.P. has agreed to call a special meeting April 4th.
- Heard report on Medicaid Subcommittee of Maryland Medical Assistance Program. Dean Kinnard commented on the Committee's discussion of acquisition cost definition. The Dean recommended non-participation of pharmacies if acquisition cost was implemented without other policy changes. He stated there was need for



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detailed total planning for cost containment, utilization, services, fees, and costs.

- Heard comments by Mr. Rubin on the proposed agenda of the Prescription Insurance Plans Committee which he is now chairing.
- Agreed to support the basic position outlined by the Dean concerning acquisition cost implementation and to seek support of all local groups.
- Referred matter of membership of pharmacists with mail order pharmacies. These members are employed by a firm engaged in mail order prescription operations.
- Agreed to grant Upper Bay Pharmaceutical Association status as a "Recognized Association" for Cecil and Harford Counties.
- Supported position of MPhA delegate to NPIC, Morris Bookoff, approving NPIC Bylaws change for independent status for NPIC.
- Received Legislative Committee report reviewing status of Senate Bill 482 (advertising of prescriptions), SB154 (Fair Trade), SB155 (advertising of prescriptions), SB223 (HMO's) and House Bill 126 (Use of prescription on label), HB164 (Increase of fees for pharmacists and pharmacies). Executive Director also reported on HB887 (Expansion of Board of Pharmacy) and HB888 (Advertising of prescription prices) introduced by Delegate Maurer.

March 8, 1973

The following is a summary of actions taken at the March 8, 1973 meeting of the Board of Trustees:

- Noted communication from the National Association of Retail Druggists regarding their efforts to include drugs in National Health Programs.
- Noted receipt of letter from APhA on correspondence with Federal Bureau of Product Safety in regards to Poison Prevention Act of 1970.
- Received President's report noting developments concerning nursing home corporation involvement in pharmacies. The President commented on his visits to Annapolis and the importance of meeting with legislators. He emphasized that the primary attention of the Executive Director was being directed to the legislature. The President appeared before the BMPA Executive Committee to discuss staffing needs. As a result, BMPA will provide additional financial assistance to MPhA towards office staffing in recognition of the heavy responsibilities and load at the office. The President expressed appreciation to the BMPA Executive Committee for their positive response.
- Approved Treasurer's Report.
- The Executive Director reported on his activities which centered on the legislature and third party payment programs including Medicaid. He noted more bills had been introduced in Annapolis than ever before. The Executive Director has been called upon to testify at a number of hearings in Annapolis.

Reported on meetings of MPhA representatives with MSHP Commission on Goals to discuss cooperative activities. Agreed on setting up joint Peer Review, Continuing Education and Legislative Committees. Also agreed that ultimate objective was for cooperative action leading to a single organization representing all pharmacy in the State of Maryland.

Other activities included meetings with BMPA officers and Executive Committee, Planned Parenthood, Professional Affairs Committee, and the Pharmaceutical Services Foundation.

- Reported the FDA has begun a program of drug surveillance with the first drug being dextroamphetamine sulfate tablets. Samples from 22 firms examined resulted in only two being found defective. Noted that Dr. Peter Lamy was named recipient of the MSHP W. Arthur Purdum Award.
- Received the Board of Pharmacy report. The Secretary reported that regulations have been proposed and are ready for hearings regarding equipment, minimum standards in nursing homes, sanitation in manufacturing plants, security, mobile pharmacies and mail order pharmacies. The Board has responded to the Dean's request for MSHP representation on the Tri-Partite Committee. The Board is adhering to the NABP guidelines to include representatives of the Board, the School and MPhA. A hospital pharmacist may be included in the school or MPhA representation. The Board has advised hospitals that legible signatures are required. The need for action as to the inclusion of a stamp on prescriptions when the name is not imprinted was discussed. Referred the matter of the number of prescriptions dispensed per pharmacist per day to the Tri-Partite Committee.
- Accepted Membership Committee Report.
- Heard Prescription Insurance Programs report noting that the Committee is drafting a program directed to savings for presentation to the state.
- Approved Legislative Committee report which reviewed status of bills in legislation. Senate Bill 482 to repeal the advertising law passed the Senate with two amendments drafted by the Executive Director. House Bill 1090 would permit the pharmacy not to stock certain narcotic drugs and post a sign to that effect. House Bill 887 would change the composition and method of appointment to the Board of Pharmacy and add two consumers. House Bill 888 has been submitted to repeal prohibitions on prescription drug advertising. MPhA has drafted a continuing education bill and a bill to leave the per diem payment for board members to the Budget Department.
- Noted activities during Poison Prevention Week. Posters, poison stickers and publicity have been arranged and pharmacies were urged to provide free Ipecac Syrup upon presentation of a physician's prescription.
- Discussed security problems in pharmacies. The Governor has been made aware of the great concern of MPhA and is seeking to determine particular problem areas.

- Endorsed participation in state or local Science Fair Award Programs.
- Agreed to oppose the inclusion of consumer representatives on the Board of Pharmacy.
- Noted APhA proposal for open enrollment of six months in which reciprocal membership would not be required. The consensus was to support open enrollment only if all current members in MPhA are "grandfathered."
- Granted Honorary Membership to Mr. Edwin Whittemore.
- Approved the following resolution: That MPhA condemns the NARD for endorsing the position of the PMA in its statement on "anti-substitution" as a policy contrary to the best interests of both the public and all pharmacists.
- Agreed to protest the packaging of Nitrobid in 60's and 100's and request that it be discontinued as Nitroglycerin must be dispensed in original containers.
- Heard report of Professional Affairs Committee noting endorsement of sponsorship of a one-day session on "Family Planning" together with Planned Parenthood. An exhibit on "Drug Product Selections" will be held at the Annual Meeting of the State Medical Society. A comprehensive poison prevention week program has been arranged.

New Members

The following is a list of the new members approved at the February 8, 1973 meeting of the Board of Trustees of the Maryland Pharmaceutical Association:

Robert J. Anderson, National Institutes of Health, Bethesda
 Gerald Beachy, Deist Pharmacy, Frostburg
 Larry J. Brendle, Bialeks Medical Arts Pharmacy
 George A. Davis
 Leonard DeMino, Peoples Drug Stores, Director of Professional Services, Washington, D.C.
 Robert L. Doolittle, Upjohn Company
 Alphonsus Ginaitis, Franklin Square Hospital, Baltimore
 Dr. Benjamin Hodes, University of Maryland, School of Pharmacy, Baltimore
 Dr. Casimir Ichniowski, University of Maryland, School of Pharmacy, Baltimore
 Michael E. Jones, Reads No. 11, Salisbury
 Yung Mei Lee, Peoples Drug Stores
 Morris Levy, Cameron Court Pharmacy, Silver Spring
 Barry Nishikawa
 Francis X. Radigan, Merck Sharp & Dohme Laboratories
 David Richman, Barr Stalford Co., Baltimore
 Joseph Stevenson, University of Maryland Hospital, Baltimore

Patrick Trost, Drug Fair
 Paul Young

The following is a list of the new members approved at the March 8, 1973 meeting of the Board of Trustees of the Maryland Pharmaceutical Association:

David J. Buresh, New Carrolltown (Drug Fair)
 Joseph H. Edelstein, Silver Spring (Drug Fair)
 Joseph L. Fine, Baltimore (Garrison Pharmacy)
 William H. Smith, College Park (Drug Fair)

Returning Recalled Amphetamines

A nationwide recall of amphetamines combined with other drugs used to treat overweight persons was announced in the March 30 *Federal Register*. To be recalled are any combinations of amphetamines, dextroamphetamine (and their salts) with other ingredients such as sedatives, tranquilizers, vitamins, etc. and parenteral injections of amphetamines.

Pharmacists need not use the Schedule II form BND-222C to return to manufacturers those amphetamine-containing drug products that are being recalled by the Food and Drug Administration as long as they are returned by June 30, 1973. However, pharmacists must retain a record showing: the pharmacy and the supplier; the date of the transaction; and the kind and exact quantity of each drug returned.

Those Schedule II drugs returned after June 30 will require use of the BND-222C form. If the drug product cannot be returned to the manufacturer, the drug product should be destroyed according to standard BNDD procedure. Pharmacists must make an exact count when returning or destroying partially-filled containers. The pharmacist should indicate the count as a fraction of the number in the original, full container—for example, 150 capsules remaining in a container of 250 capsules should be indicated as "150/250".

Pharmacists should note that *oral* dosage forms of amphetamine or dextroamphetamine alone, or of those substances in *combination* with each other, are not subject to this recall. Also, single entity *oral* methamphetamine dosage forms are *not* included in this recall.

Also, the following amphetamine combinations are *not* presently subject to the recall because hearings have been requested by their manufacturers, and pharmacists can *continue* to dispense them upon prescription-order:

Bamadex Sequels (Lederle); Delcobese capsules, Delcobese sustained release capsules, Delcobese tablets, and Delcobese sustained release tablets (Delco); Dexamyl Elixir, Dexamyl Spansules No. 1 and No. 2, and Dexamyl tablets (Smith Kline & French); Eskatrol Spansules (SK & F); Obetrol-10 and Obetrol-20 tablets (Obetrol-Rexar).

FAMILY PLANNING WORKSHOP

Scheduled For Pharmacists

June 7, 1973

The Planned Parenthood Association of Maryland, in cooperation with the Maryland Pharmaceutical Association, will sponsor a one-day workshop entitled, **THE PHARMACIST: VITAL LINK IN THE DISTRIBUTION OF FAMILY PLANNING SERVICES.**

The workshop will be held on June 7, 1973, at the Family Planning Training Institute, the professional training facility of the Planned Parenthood Association. Pharmacists throughout the state of Maryland are invited to attend.

The purposes of the workshop are threefold: (1) to provide information relating to the medical, legal, and psycho-social aspects of family planning, (2) to enhance the pharmacist's ability to provide information and advice about birth control methods, and (3) to explore various roles which pharmacists may assume in the delivery of family planning information and services. Workshop faculty will include highly qualified professionals from the fields of pharmacy, medicine, nursing, and social work.

Highlighting the workshop will be the keynote address during luncheon entitled, "The Role of the Pharmacist in Family Planning." The address will be delivered by Samuel H. Kalman, a pharmacist and Program Planning and Technical Services Officer with the Virginia Regional Medical Program.

Mr. Kalman will present a model incorporating a broad range of vitally important roles for the pharmacist in the field of family planning. Featured also will be workshop sessions dealing with the most recent medical developments in the field, common questions which pharmacists encounter regarding family planning, and with relevant and provocative issues relating to the broader field of human sexuality.

Topics discussed throughout the day will include "Human Sexuality: What's New in 1973"? — a minilab in communication, conducted by Stanley Z. Mazer, M. S. W., ACSW, Professor of Urban Affairs, Community College of Baltimore.

Speeches are also scheduled on "Medical Aspects of Contraception: Current Issues and Developments" given by Donald Chambers, M.D., FACOG, Obstetrician-Gynecologist, Garwyn Medical Center; "Modern Techniques of Sterilization and Abortion," by Frances Trimble, M.D., Medical Director, Planned Parenthood; "Understanding Adolescent Sexuality: The Role of the Health Professional," by Murray Kappelman, M.D., Associate Professor of Pediatrics, University of Maryland School of Medicine; and "Psychological and Sociological Factors Affecting the Use of Contraceptives," Susan Fischman, M.P.H. CNM, instructor, Johns Hopkins University School of Hygiene and Public Health.

At 3 p.m., there will be a panel: "Common Types of Questions the Pharmacist Encounters When Asked to Give Advice on the Use of Contraceptives." The panel will consist of Samuel H. Kalman, R.Ph.; Bernard Lachman, community pharmacist, President Maryland Pharmaceutical Association; David S. Roffman, Instructor of Clinical Pharmacy, University of Maryland School of Pharmacy and Frances Trimble, M.D.

Interspersed throughout the day will be reports of related findings of the "1973 Family Planning Survey of Maryland Pharmacies," another joint project of PP/Md and the MPhA. This survey, a comprehensive one in design, dealt primarily with the attitudes and practices of Maryland Pharmacists relating to the sale and display of contraceptives. Reflected in the survey results are a high degree of interest in family planning among community pharmacists and their desire to enhance expertise in this area.

Pharmacists who are interested in receiving registration information for the workshop should contact the Maryland Pharmaceutical Association, 650 West Lombard Street, Baltimore, Maryland 21201, 301-727-0746. The registration fee will be \$10.00 including luncheon. The Family Planning Training Institute is located on the fourth floor of the YMCA building located at 24 West Franklin Street in Baltimore.

Cataract Booklet Available

Nearly 5,000 people in the United States will lose their sight this year from cataract. However, permanent blindness from cataract is usually needless. To explain this disease and its treatment, the National Eye Institute has issued the booklet, *Cataract: NEI Focus on Research*.

A cataract is a cloudiness in the lens of the eye which interferes with vision. While the cause cannot usually be determined, cataract extraction is one of the most successful operations performed today. From 90 to 95 per cent of all patients undergoing cataract surgery enjoy restoration of sight.

Written for the general public, single copies of *Cataract: NEI Focus on Research* are available free from the Office of Information, National Eye Institute, National Institutes of Health, Bethesda, Maryland 20014.

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Annual Report of the Maryland Board of Pharmacy

1971 1972

In compliance with the provisions as set forth in Section 258 of Article 43 of the Annotated Code of Maryland, this report is submitted to the Honorable Marvin Mandel, Governor of Maryland and to the Maryland Pharmaceutical Association. This is the seventieth report to the Governor of the State and the sixtieth to the Association. The report covers the activities of the Maryland Board of Pharmacy for the fiscal year ending June 30, 1972. This report is also being submitted to the Secretary of Health and Mental Hygiene, the McKeldin Library of the University of Maryland, the Enoch Pratt Free Library, the Department of Legislative Reference, the Hall of Records and the State Library.

Personnel

During the year the Board held fourteen meetings, five of which were held at the School of Pharmacy of the University of Maryland, for the purpose of conducting examinations for registration of pharmacists.

At its first meeting the Board reorganized and elected Mr. Norman J. Levin President and Mr. F. S. Balassone Secretary-Treasurer. The other members of the Board were: Messrs. Howard L. Gordy, Morris R. Yaffe and Frank Block.

On January 2, 1972 the pharmaceutical world of our State and Nation was dealt a stunning blow. It was on this date that Francis S. Balassone, the Secretary of the Maryland Board of Pharmacy since 1955 was stricken and taken from our midst. The Maryland Board of Pharmacy had introduced into its Board minutes many expressions of sympathy of which a Senate Resolution of the State Legislature was one. As its tribute to Frank, the Board introduced an expression of its own feelings entitled, "Farewell to Frank Balassone." The Board hereby makes this Farewell a part of this report.

Farewell To Frank Balassone

We, the Members of the Maryland Board of Pharmacy were deeply grieved at the pronouncement that our Secretary, Francis S. Balassone had been suddenly called to the Great Beyond. This shock of his departure from within our midst brought to us the realization that we had had the privilege of being closely associated with him, both as co-worker and friend.

We shall not use these lines to again enumerate his many accomplishments. These will be recorded in many places and in many ways, the foremost being the very pages of this minute book. However, we prefer to salute Frank Balassone the Man. We take note of his congenial personality and the impact this had made upon our lives and the lives of other of his associates. Frank had earned

for himself and those working with him much respect and admiration. His priest referred to him as a gentle man—this quality magnified his dedication and leadership within the many spheres of life into which he entered.

Recently, in his office, Frank was responding to questions on his philosophies of person to person relationships as they encompassed Law—Order—Justice and Virtue. Of Virtue Frank said, "THE GOODNESS OF AN INDIVIDUAL IS REFLECTED IN HIS TOTAL PERSON AND IN HIS CONDUCT WITH TOTAL PERSONS. THIS REPRESENTS A MAN BEING UPRIGHT IN SUCH THINGS AS PRUDENCE, FAITH, TEMPERANCE, HOPE, KINDNESS, CHARITY AND LOVE. IF WE HAD THEN, PEOPLE WHO WERE VIRTUOUS AND JUST WE WOULD NEED LESS OF THE FORMALITY OF ORDER AND LAW WHICH ARE MAN MADE RULES FOR CONDUCT WITH AND FOR EACH OTHER."

Norman J. Levin, President
Howard L. Gordy
Morris R. Yaffe
Frank Block

Examination

The Board conducted two examinations for registration of pharmacists during the fiscal year. They were held at the School of Pharmacy of the University of Maryland on November 3, 4 and 5, 1971 and on June 12 and 13, 1972.

There were twelve applicants for the full Board in November, Eleven passed both the theoretical and practical portions of the examination and were subsequently registered. One failed the examination.

Having previously passed the theoretical portion of the examination, seventy-three candidates took the practical examination in November. All of these candidates passed and were subsequently registered.

Three applicants took only the theoretical portion of the examination. All of these passed and will take the practical examination upon completion of their practical experience.

Five applicants took only the practical portion of the examination, as they did not have the required experience for reciprocity. These applicants passed and were subsequently licensed by reciprocity in Maryland.

In June forty-five applicants took the full Board examination. Forty-two passed both the theoretical and practical portions of the examination and were subsequently registered. Three failed this examination.

Having previously passed the theoretical portion of the examination, nine took the practical examination. Eight of these applicants passed this portion of the examination and were subsequently registered. One failed this portion of the examination.

Twenty-four applicants took only the theoretical portion of the examination, as they did not have the required experience to take the full Board. Of these seventeen passed and seven failed this portion of the examination.

Three applicants took only the practical portion of the examination, as they did not have the required experience for reciprocity. All of these applicants passed and were subsequently licensed by reciprocity in Maryland.

The Standard Examination of the National Association of Boards of Pharmacy was given, which consisted of the following subjects:

Chemistry
Pharmacy
Mathematics
Pharmacology
Practical Pharmacy

Record of Examinations Held

November 3, 4 and 5, 1971

Applicants	Passed	Withheld	Failed
87	83	3	1

June 12 and 13, 1972

Applicants	Passed	Withheld	Failed
78	50	17	11

Total Number Examined for Registration as Pharmacists

Applicants	Passed	Withheld	Failed
165	133	20	12

The following table shows the number of pharmacists who were registered by examination during the past ten years:

Year	Number of Pharmacists
1962-1963	74
1963-1964	100
1964-1965	11
1965-1966	64
1966-1967	58
1967-1968	41
1968-1969	60
1969-1970	93
1970-1971	112
1971-1972	133

As in the past many pharmacists applied for reciprocal registration in Maryland in order to accept positions with their employers who are opening stores in Maryland.

Those applicants who did not meet our requirements concerning practical experience prior to or after registration were advised that they must take our practical examination in order to verify their qualifications.

In all cases an applicant for reciprocal registration must appear for a personal interview. The entire Board must act on whether or not to grant registration to such applicants, who must sign an agreement to comply with Maryland's laws pertaining to drugs and pharmacy.

The following table shows those granted registration by reciprocity thus far during the 1972 Fiscal Year:

Registered By Reciprocity

Name	Certificate Number	Dated	State
Nathan D. Chalmson	7419	July 1, 1971	Wisconsin
Elmer A. Cook, Jr.	7420	July 2, 1971	Texas
Norman C. Dankelmann	7421	July 2, 1971	Pennsylvania
William A. Odum, Jr.	7440	July 27, 1971	Tennessee
David Alt	7441	July 30, 1971	Dist. of Columbia
Nancy L. M. Arnell	7442	July 30, 1971	Indiana
Paul D. Coomler	7443	July 30, 1971	Indiana
Gerald R. Hajarjan	7444	July 30, 1971	Massachusetts
James K. Hooper	7445	July 30, 1971	Utah
Anthony W. Lentine	7446	July 30, 1971	Massachusetts
Patricia G. Libano	7447	July 30, 1971	Connecticut
Leo Welner	7448	July 30, 1971	New York
Henry L. Pelletier, Jr.	7449	Aug. 20, 1971	Massachusetts
Bruce E. Bjornberg	7450	Aug. 26, 1971	Illinois
Robert P. Grelak	7451	Aug. 26, 1971	Illinois
Grady L. McLemore	7452	Aug. 26, 1971	Texas
Jacob L. Berkowitz	7454	Sept. 21, 1971	Pennsylvania
Richard S. Welberg	7455	Sept. 21, 1971	Dist. of Columbia
Kenneth D. Wilson	7456	Sept. 21, 1971	Tennessee
Paul A. Felcht, Jr.	7459	Oct. 4, 1971	Pennsylvania
Henry Krutz	7461	Oct. 26, 1971	Pennsylvania
Frank W. Anastasia	7462	Oct. 27, 1971	Virginia
Edward B. Furr	7463	Oct. 27, 1971	Dist. of Columbia
Carolyn A. Lussier	7464	Oct. 27, 1971	Massachusetts
Joyce G. Sapperstein	7465	Oct. 27, 1971	Dist. of Columbia
Robert A. Statler	7466	Oct. 27, 1971	Pennsylvania
John S. Cipriano	7467	Nov. 18, 1971	Massachusetts
William W. Gibson, Jr.	7468	Nov. 18, 1971	Dist. of Columbia
James L. Helfrich	7469	Nov. 18, 1971	Pennsylvania
David Morris	7470	Nov. 18, 1971	Pennsylvania
Paul J. Vilik	7471	Nov. 18, 1971	New York
Norman Barshal	7544	Dec. 9, 1971	Pennsylvania
Raymond M. Borland, Jr.	7545	Dec. 9, 1971	Pennsylvania
Peter Garofalo	7546	Dec. 9, 1971	Dist. of Columbia
Larry M. King	7547	Dec. 9, 1971	Pennsylvania
Kathleen A. McGee	7548	Dec. 9, 1971	Pennsylvania
Anthony A. Patane	7549	Dec. 9, 1971	Pennsylvania
Charles A. Powell	7550	Dec. 9, 1971	Kansas
Diane K. Willis	7551	Dec. 9, 1971	Pennsylvania
Terry F. Willis	7552	Dec. 9, 1971	Pennsylvania
Kermit I. Carter, Jr.	7553	Dec. 15, 1971	Dist. of Columbia
Richard W. Ottmar	7554	Dec. 15, 1971	North Carolina
Martin M. Silver	7555	Dec. 20, 1971	Pennsylvania
Robert S. Arnell	7556	Jan. 11, 1972	Iowa
Dora M. Gonzalez	7557	Jan. 11, 1972	Texas
John James Hoste	7558	Jan. 11, 1972	New York
Margaret E. W. Stump	7559	Jan. 11, 1972	West Virginia
Nancy C. Connel	7560	Jan. 11, 1972	Connecticut
Elizabeth A. W. Grove	7561	Jan. 28, 1972	Pennsylvania
Charlotte J. Smith	7563	Feb. 7, 1972	North Carolina
Shella K. West	7564	Feb. 7, 1972	Nevada
James C. Coleman	7568	Mar. 7, 1972	Michigan
Joseph L. Perouz	7569	Mar. 7, 1972	Dist. of Columbia
Harry C. Georgerian	7575	April 4, 1972	New Jersey
Elmer C. Hillman, Jr.	7576	April 4, 1972	New Jersey
John E. McClellan, Jr.	7577	April 4, 1972	Delaware
May K. Rose	7578	April 4, 1972	Ohio
Leonard Felgenbaum	7580	April 13, 1972	New York
Rosalind H. Reid	7583	May 1, 1972	Texas
Marion S. Alley, Sr.	7584	May 22, 1972	Dist. of Columbia
Frederick E. Battle	7585	May 22, 1972	Arkansas
Peter P. S. Tam	7586	May 22, 1972	Minnesota
Robert L. Koenig	7588	June 14, 1972	Virginia
Jean H. Paxinos	7589	June 14, 1972	Pennsylvania
Paul Grossman	7590	June 19, 1972	New Jersey
William Y. Radcliff	7591	June 19, 1972	Oklahoma
Alice H. S. Ikeda	7592	June 20, 1972	Ohio

The following table shows the number of pharmacists granted registration by reciprocity and the number who were certified to register by reciprocity in other states during the past ten years:

Fiscal Year	Reciprocity	Certified for Registration in Other States
1962-1963	54	18
1963-1964	46	23
1964-1965	63	20
1965-1966	44	25

1966-1967	61	27
1967-1968	64	20
1968-1969	84	27
1969-1970	75	40
1970-1971	92	26
1971-1972	67	35
Total	650	261

The table shows Maryland gained 389 pharmacists by reciprocity during the past ten years.

Pharmacy Permits

Location	1970-1971	1971-1972
Counties:		
Allegany	21	22
Anne Arundel	54	52
Baltimore	148	143
Calvert	2	2
Caroline	3	3
Carroll	12	14
Cecil	9	7
Charles	7	7
Dorchester	4	4
Frederick	14	14
Garrett	3	3
Harford	20	21
Howard	10	10
Kent	3	3
Montgomery	82	89
Prince George's	98	98
Queen Anne's	4	4
Saint Mary's	4	5
Somerset	4	3
Talbot	8	7
Washington	16	15
Wicomico	12	13
Worcester	6	6
County Totals	544	545
Baltimore City	223	216
State-wide Totals	767	761

The above figures include permits issued to hospitals in the counties as follows:

Allegany	2	Montgomery	4
Anne Arundel	2	Prince George's	3
Baltimore	5	St. Mary's	1
Carroll	1	Talbot	1
Cecil	1	Washington	1
Frederick	1	Wicomico	1
Harford	1		
Howard	1	Total	25

In Baltimore City, 18 hospitals received a permit to operate a pharmacy. Thus, a total of 43 hospitals have a licensed pharmacy. Two nursing homes, three clinics and one State Penal Institution have received pharmacy permits.

From July 1, 1971 to the present time permits have been issued to 17 new pharmacies. A total of 21 pharmacies have closed and have not, as yet, been re-opened as pharmacies.

The following table shows the number of pharmacies opened, changes in ownership and closed during the year:

	Opened	Changes in Ownership Corporation, and/or Address	Closed
Counties	11	8	11
Baltimore City	6	3	10
Total	27	11	21

The following table shows the number of pharmacies opened, changes in ownership, etc. and closed in the past ten years:

Fiscal Year	Opened	Changes	Closed
1962-1963	39	45	22
1963-1964	20	38	20
1964-1965	22	34	20
1965-1966	27	46	44
1966-1967	41	27	25
1967-1968	24	37	35
1968-1969	34	19	51
1969-1970	20	21	19
1970-1971	24	28	40
1971-1972	27	11	21

Certificate of Registration Renewals

The following shows the renewal periods and the total renewals to date:

Renewal Period	Total Renewals
1961-1962	2,358
1963-1964	2,414
1965-1966	2,651
1967-1968	2,750
1969-1970	2,880
1971-1972	3,043

Manufacturer's Permits

Permits to manufacture drugs, medicines, toilet articles, dentifrices or cosmetics during 1972 were issued to 42 firms, 31 of which were "limited" permits. An applicant applying for a permit for a newly established company is required to appear before the Board and to furnish all information the Board considers pertinent to the conducting of such operation.

Dangerous Drug Distributors' Permit

The Board issued 122 permits to sell, distribute, give or in any way dispose of dangerous drugs during 1972. It is not necessary for a subsidiary or subsidiaries of a company to have a separate permit, as they are covered under the permit held by the parent company.

Legislation

The following bills were introduced and passed in the 1972 session of the General Assembly.

House Bill No. 89. (Chapter 487)

AN ACT to add new Subsections (a-1), (a-2) and (b-1) to Section 285(a) and (b) of Article 27 of the Annotated Code of Maryland (1971 Replacement Volume), title "Crimes and Punishments," subtitle "I. Crimes and Punishments," subheading "Health-Controlled Dangerous Substances," to follow immediately after Sections 285 (a), 285 (b) respectively to provide that certain controlled dangerous substances may not be dispensed by a practitioner in any manner, unless a recognized emergency or medical situation exists, or unless the Department of Health and Mental Hygiene has sanctioned a therapy program which requires the use of a certain substance which must be dispensed by a practitioner.

SECTION 1. Be it enacted by the General Assembly of Maryland, That new sub-sections (a-1), (a-2) and (b-1) be and the same are hereby added to Section 285(a) and (b) of the Annotated Code of Maryland (1971 Replacement Volume), (1971 Supplement), title "Crimes and Punishments," subtitle "I. Crimes and Punishments," subheading "Health-Controlled Dangerous Substances," and to read as follows:

285. (Article 27)

(a) Except when dispensed directly by a practitioner, other than a pharmacist to an ultimate user, no controlled dangerous substance included in Schedule II, which is a prescription drug as determined under Article 43, may be dispensed without the written prescription of a practitioner: Provided, that in emergency situations, as prescribed by the Department by regulation, such drug may be dispensed upon oral prescription reduced promptly to writing and filed by the pharmacist, if such oral prescription is authorized by federal laws. Prescriptions shall be retained in conformity with the requirements of Section 282 of this subheading, as amended from time to time. No prescription for a Schedule II substance may be refilled.

(a-1) No practitioner shall dispense Methadone, directly or by prescription, unless he is associated with a controlled drug therapy program sanctioned by the Drug Abuse Administration of the Department, or unless an emergency or medical situation as prescribed by the Department by regulation, in cooperation with the Medical and Chirurgical Faculty of Maryland, exists.

(a-2) No practitioner shall dispense Methamphetamine, directly or by prescription, except in recognized cases of medical need, as prescribed by the Department by regulation in cooperation with the Medical and Chirurgical Faculty of Maryland.

(b) Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled dangerous substances included in Schedule III or IV which is a prescription drug as determined under Article 43, may be dispensed without a written or oral prescription. Such prescription may not be filled or re-

filled more than six months after the date thereof or be refilled more than five times after the date of the prescription, unless renewed by the practitioner.

(b-1) No practitioner shall dispense Amphetamine, directly or by prescription, except in recognized cases of medical need, as prescribed by the Department by regulation in cooperation with the Medical and Chirurgical Faculty of Maryland.

SECTION 2. And be it further enacted, That this Act shall take effect July 1, 1972.

House Bill No. 109. (Chapter 488)

AN ACT to add new Section 254B to Article 43 of the Annotated Code of Maryland (1971 Replacement Volume), title "Health," subtitle "Commissioners of Pharmacy," to follow immediately after Section 254A thereof, to prohibit a pharmacist from selling or dispensing any medications on prescription presented more than thirty (30) days from the date it was issued by a physician or dentist, and to require the physician or dentist to indicate the date of issuance on the prescription and the pharmacist to indicate the date on which the prescription is filled.

SECTION 1. Be it enacted by the General Assembly of Maryland, That new Section 254B be and it is hereby added to Article 43 of the Annotated Code of Maryland (1971 Replacement Volume), title "Health," subtitle "Commissioners of Pharmacy," to follow immediately after Section 254A, and to read as follows:

254B. (Article 43)

No pharmacist may sell or dispense any medications on prescriptions presented more than thirty (30) days from the date it was issued by a physician or dentist, unless otherwise indicated by the issuing physician or dentist. The physician or dentist shall indicate on the prescription the date of issuance. The pharmacist shall indicate on the prescription label the date on which the prescription is filled.

House Bill No. 1160. (Chapter 591)

AN ACT to add new Section 187B(19) to Article 43 of the Annotated Code of Maryland (1971 Supplement), title "Health," subtitle "Adulteration of Food and Drink," subheading "Maryland Food, Drug and Cosmetic Act" to follow immediately after Section 187B(18) thereof, and to repeal and reenact, with amendments, Section 189B(10) of Article 43 of the Annotated Code of Maryland (1971 Supplement), title, "Health," subtitle "Adulteration of Food and Drink," subheading "Maryland Food, Drug and Cosmetic Act" to prohibit the withholding of certain information by prescription drug manufacturers, packers, and distributors, in certain cases, to provide for disclosure of information by certain persons in certain cases to the Secretary of Health and Mental Hygiene, and generally relating to the acts of prescription drug manufacturers, packers and distributors.

SECTION 1. Be it enacted by the General Assembly of Maryland, that new Section 187B(19) be and it is

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Current inventories are not always easy to maintain. At Roche, we understand your difficulties and want to do all we can to help you keep your stock up-to-date.

The Roche Retrieval Program is part of our effort to facilitate the return of previously discontinued Roche items. It offers you an opportunity to convert these no longer usable products into cash.

An Explanatory Mailing, scheduled for early February, will include a letter describing the program, a 6-part return goods form listing the approximately 95 items discontinued over the years, and a BRC for pharmacies which have no returnable merchandise.

All You Need Do is check your inventory for the listed items, calculate their return value and return them to Roche. If you have none of the items, please indicate this on the BRC and send it to Roche.

You Will Receive A Check for the value of items which you return, plus your postage costs.

Our Established Return Goods Policy is in no way altered by this special campaign. Only those products specified in the returned goods form may be returned under this program; other unsalable Roche items must be handled separately and in the customary manner.

**The Roche Retrieval Program will
end on April 30, 1973—so don't delay
in returning your discontinued items.**



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hereby added to Article 43 of the Annotated Code of Maryland (1971 Supplement), title "Health," subtitle "Adulteration of Food and Drink," subheading "Maryland Food, Drug and Cosmetic Act" to follow immediately after Section 187B(18); and that Section 189B(10) be and it is hereby repealed and re-enacted, with amendments, to Article 43 of the Annotated Code of Maryland (1971 Supplement), title "Health," subtitle "Adulteration of Food and Drink," subheading "Maryland Food, Drug and Cosmetic Act" and all to read as follows:

187B. (Article 43)

(19) In the case of a prescription drug distributed or offered for sale in this state, the failure of the manufacturer, packer, or distributor thereof to provide, upon specific written detailed request by the Secretary, the information which it possesses pertinent to the biological availability and clinical performance of the drug and of any comparative data of drug products of the same established name of other manufacturers, packers or distributors.

189B.

10)(a) If it is a drug and its container is so made, formed, or filled as to be misleading; or

(b) If it is an imitation of another drug; or

(c) If it is offered for sale under the name of another drug; or

(New) (d) In the case of prescription drug, if the label or information accompanying the package fails to show the name of the actual manufacturer of the drug, when the manufacturer is different from the repackager or distributor; however, in the event a prescription drug is manufactured or fabricated by one company pursuant to the specifications of another company and the latter company accepts full responsibility for the integrity of the product, only the name of the company assuming responsibility need appear on the label, provided a statement is filed with the Department of Health and Mental Hygiene disclosing the name of the manufacturer or fabricator.

SECTION 2. And be it further enacted, That this Act shall take effect July 1, 1972.

House Bill No. 573 (Chapter 704)

AN ACT to repeal and re-enact, with amendments, Section 187B(17) of Article 43 of the Annotated Code of Maryland (1971 Supplement), title "Health," subtitle "Adulteration of Food and Drink," and to add new Section 273A to said Article of said Code (1971 Replacement Volume), title "Health," subtitle "Commissioners of Pharmacy," to follow immediately after Section 273 thereof, to remove a certain restriction on dispensing of drugs, to define certain terms, to permit dispensing of different brand or non-brand name drug products under certain circumstances, and relating generally to drug prescriptions.

SECTION 1. Be it enacted by the General Assembly of Maryland, that Section 187B (17) of Article 43 of the Annotated Code of Maryland (1971 Supplement), title "Health," subtitle "Adulteration of Food and Drink," be and it is hereby repealed and re-enacted, with amendments; and that new Section 273A be and it is hereby

added to said Article of said Code (1971 Replacement Volume), title "Health," subtitle "Commissioners of Pharmacy," to follow immediately after Section 273 thereof, and all to read as follows:

187B.

(17) Dispensing or causing to be dispensed a different drug or brand of drug in place of the drug or brand of drug ordered or prescribed without the permission in each case of the person ordering or prescribing.

273A.

(a) As used in this section, "brand name" means the proprietary name the manufacturer places upon a drug product or on its container label or wrapping at the time of packaging; and "established name" shall have the same meaning as assigned that term by the Federal Food, Drug and Cosmetic Act as amended, Title 21 U.S.C. 301 et seq.

(b) Unless the physician or other authorized prescriber explicitly states otherwise when transmitting an oral prescription or in the instance of a written prescription, indicates in his own writing or by initialing an appropriate imprinted statement, a different brand name or nonbrand name drug product of the same established name may be dispensed by a pharmacist provided, however, that such action by the pharmacist shall be authorized only if in each case the pharmacist immediately transmits notice in writing to the prescriber specifying the drug product actually dispensed and in the name of the manufacturer or distributor.

(c) The provisions of this section shall only apply to those drug products included in the Maryland Medical Assistance Formulary determined by the Maryland Department of Health and Mental Hygiene on the basis of scientific evidence to be clinically equivalent.

(d) In any instance in which the pharmacist, pursuant to this section dispenses a different drug product from that prescribed, the pharmacist shall pass on the full savings in cost, being the difference between the wholesale prices of the two drug products, to the consumer.

SECTION 2. And be it further enacted, That this Act shall take effect December 1, 1972.

House Bill No. 402. (Chapter 508)

AN ACT to repeal and re-enact with amendments, Section 326(1) and Section 326(M) of Article 81 of the Annotated Code of Maryland (1969 Replacement Volume and 1971 Supplement), title "Revenue and Taxes," subtitle "Retail Sales Tax Act." subheading "In General," to exempt disposable medical supplies, orthopedic appliances, surgical appliances, hospital beds, oxygen tents, and other medicines and sick room equipment from retail sales tax and generally relating thereto.

SECTION 1. Be it enacted by the General Assembly of Maryland, that Section 326(1) and Section 326(M) of Article 81 of the Annotated Code of Maryland (1969 Replacement Volume and 1971 Supplement), title "Revenue and Taxes," subtitle "Retail Sales Tax Act." subheading "In General," be and they are hereby repealed

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and re-enacted, with amendments, to read as follows:

326. (Article 81)

(1) Sales of medicines and disposable medical supplies sold on prescriptions of physicians, or medicines compounded, processed or blended by a druggist offering the same for sale at retail, or sales of drugs or medical supplies to physicians or hospitals or by physicians and hospitals to patients in connection with medical treatments, sales of baby oils and baby powders, and any other medicines as this term may be defined by regulations of the comptroller.

(M) Sales of crutches, and sales of artificial limbs, artificial eyes, artificial hearing devices, corrective eyeglasses, orthopedic appliances and surgical appliances when the same are designed to be worn on the person of the owner or user when prescribed by a physician, the sales of colostomy and ileostomy appliances, and the sales of wheelchairs for invalids, hospital beds, oxygen tents, and other sick room equipment as may be defined by regulations of the comptroller.

SECTION 2. And be it further enacted, That this Act shall take effect July 1, 1972.

Senate Bill No. 195 (Chapter 393)

AN ACT to repeal and re-enact, with amendments, Section 266A(c) of Article 43 of the Annotated Code of Maryland (1971 Replacement Volume), title "Health," subtitle "Commissioners of Pharmacy," to limit, under certain conditions in the case of pricing and services for persons age 60 and over, the power of the Pharmacy Board to take action against a pharmacist for advertising prescription, dangerous or non-proprietary drug prices.

SECTION 1. Be it enacted by the General Assembly of Maryland, That Section 266A(c) of Article 43 of the Annotated Code of Maryland (1971 Replacement Volume), title "Health," subtitle "Commissioners of Pharmacy," be and the same is hereby repealed and re-enacted, with amendments, to read as follows:

266A

(c) The Board's power either to reprimand a pharmacist or assistant pharmacist or to suspend or revoke his license shall be for any of the following causes:

(1) Conviction of:

(i) A crime involving professional misconduct respecting the pharmacy or drug laws.

(ii) A crime involving the State Uniform Narcotic Drug Act or the federal narcotic laws.

(iii) His addition to the use of morphine, cocaine, or narcotics of any kind.

(iv) His knowingly, intentionally or fraudulently adulterating, or causing to be adulterated, drugs, chemicals or medicinal preparations.

(2) Procuring, or attempting to procure, registration in Maryland as a pharmacist for himself or another by knowingly making or causing to be made false representations to the Board.

(3) Adjudication as an incompetent under the provisions of Article 59 of this Code.

(4) Upon proof satisfactory to the Board of Pharmacy that a pharmacist or assistant pharmacist is guilty of grossly unprofessional conduct. The following acts on the part of a pharmacist or assistant pharmacist are hereby declared to constitute grossly unprofessional conduct:

(i) Paying rebates or entering into an agreement for payment of rebates to any physician, dentist or other person for the recommending of the services of any person.

(ii) The providing or causing to be provided to physician, dentist, veterinarian, or other medical practitioners, prescription blanks or forms bearing the pharmacists' or pharmacy's name, address or other means of identification.

(iii) The association by a pharmacist either as a partner, coowner, or employee of a pharmacy, wholly or substantially owned by physician, dentist, veterinarian, or other medical practitioner or group thereof; but this paragraph shall not be construed or applied to have any retroactive effect or to apply to any such association existing on June 1, 1963, for such period as that association remains in continuous existence.

(iv) The advertising to the public by any means, in any form or through any media, the prices for prescriptions, dangerous or nonproprietary drugs, or fees for services relating thereto or any reference to the price of said drugs or prescriptions whether specifically or as a percentile of prevailing prices, or by the use of the terms "cut rate," "discount," "bargain" or terms of similar connotation; provided, that the dissemination of information by a pharmacist, directly or indirectly, through any state sponsored agency or any group recognized by the Maryland Commission on Aging, of special pricing and/or services, without identifying individual prescription drug items, to residents of the State of Maryland who have attained 60 years of age, shall not constitute unprofessional conduct within the meaning of this subtitle.

(v) The advertising or claiming to the public of professional superiority in the compounding or filling of prescriptions or in any manner implying professional superiority which may undermine public confidence in the ability, character and integrity of other pharmacists.

SECTION 2. And be it further enacted, That this Act shall take effect July 1, 1972.

Senate Bill No. 621 (Chapter 223)

AN ACT to repeal and re-enact, with amendments, Section 354 of Article 48A of the Annotated Code of Maryland (1972 Replacement Volume), title "Insurance Code," subtitle "20. Nonprofit Health Service Plans," to prohibit any nonprofit health insurance plan providing pharmaceutical services from denying to any subscriber, member or beneficiary freedom of choice of pharmacy.

SECTION 1. Be it enacted by the General Assembly of Maryland, that Section 354 of Article 48A of the Annotated Code of Maryland (1972 Replacement Volume), title "Insurance Code," subtitle "20. Nonprofit Health Service Plans," be and it is hereby repealed and re-

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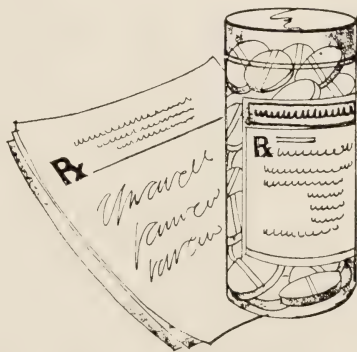
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enacted, with amendments, to read as follows:

254.

(a) Any corporation without capital stock heretofore or hereafter organized, under the provisions of Article 23 of the Code of Public General Laws of this State, for the purpose of establishing, maintaining and operating a nonprofit health service plan whereby hospital, medical, chiropodial, pharmaceutical, dental or optometric care is provided by a hospital, or hospitals, a physician or physicians, a chiropodist or chiropodists, a pharmacist or pharmacists, a dentist or dentists, and/or an optometrist or optometrists, to persons who become subscriber to such plan under contracts which entitle each subscriber to certain hospital, medical, chiropodial, pharmaceutical, dental or optometric care or any of them, shall be governed and regulated by the provisions of this subtitle, and by no other law relating to insurance unless such law is referred to under this subtitle, and no law hereafter enacted shall apply to such corporations, unless they are expressly designated therein, and specifically refer to such corporations.

(b) Any nonprofit health plan which provides pharmaceutical services shall grant to any subscriber, member or beneficiary the right to have any prescription filled at the pharmacy of the subscriber's, member's, or beneficiary's choice.

SECTION 2. And be it further enacted, that this Act shall take effect July 1, 1972.

House Bill No. 1076 (Chapter 582)

AN ACT to repeal and re-enact, with amendments, Section 53 of Article 40 of the Annotated Code of Maryland (1971 Replacement Volume), title "General Assembly," subtitle "Department of Legislative Reference," to require all officers, agencies, boards, commissions, and other units of State Government to file one copy of every report, bulletin, periodical, catalog and other publication issued by them with the McKeldin Library of the University of Maryland and the Enoch Pratt Free Library (Central Branch).

SECTION 1. Be it enacted by the General Assembly of Maryland, That Section 53 of Article 40 of the Annotated Code of Maryland (1971 Replacement Volume), title "General Assembly," subtitle "Department of Legislative Reference," be and it is hereby repealed and re-enacted, with amendments, to read as follows:

53.

It is the duty of every officer, board, institution and commission of the State, including special or temporary officers, boards and commissions, to file with the Department of Legislative Reference two copies of every regular or special report, bulletin, periodical, catalog and other publication issued by him or it, whether the report is in printed or other form, and also to file with the State Library, the Hall of Records, the McKeldin Library of the University of Maryland, and the Enoch Pratt Free Library (Central Branch) at least one copy of the report or other publication.

SECTION 2. And be it further enacted, That this Act shall take effect July 1, 1972.

Rules for Formal Hearing—Effective: September 1, 1971

I. Maryland Board of Pharmacy — Rules for Formal Hearings

A. Definitions

1. "Board shall mean the Maryland Board of Pharmacy
2. "Party" shall mean any person, firm, corporation, or agent named or admitted as a party, or properly seeking and entitled as of right to be a party in formal hearings.
3. "Pharmacist" shall mean any person licensed as such by the Maryland Board of Pharmacy.

B. Scope

These rules shall apply to all formal hearings before the Maryland Board of Pharmacy. They do not apply to conferences or other informal investigations or proceedings at or upon which no formal rulings or decision is made or is to be made.

C. Notice of Hearing

Written notice of all hearings shall be sent by the Secretary of the Board to all parties at least twenty (20) days prior thereto. The notice shall state the date, time and place of the hearing. It shall also state the complaint and charges involved in the proceeding.

D. Parties — Representation

Any party who may be called to appear before the Board shall be entitled to be represented by counsel. All proceedings of the Board shall be subject to the provisions of the Administrative Procedures Act.

E. Record — Transcript

1. The Board shall prepare an official record of hearings which shall include all pleadings, testimony, exhibits, and other memoranda or material filed in the proceeding.
2. Unless waived by all parties, a stenographic record of the proceedings shall be made at the expense of the Board. Such record shall not be transcribed, however, unless requested by a party or by the Board. The cost of any type-written transcripts of any proceedings, or parts thereof, shall be paid by the party requesting such transcript.

F. Quorum

Three (3) members of the Board shall constitute a quorum thereof and all hearings shall be held before not less than a quorum of the Board.

G. Presiding Officer

The President, or in his absence a member designated by him, shall be the Presiding Officer, and shall have complete charge of the hearing, permit the examination of witnesses, admit evidence, rule

on the admissibility of evidence, and adjourn or recess the hearing from time to time.

H. Order of Procedure

The order in which the parties shall present their case shall be determined by the Presiding Officer.

I. Examination of Witnesses and Introduction of Evidence

1. The rules of evidence in all hearings before the Board shall be as set forth in Article 41, Section 252, of the Annotated Code of Maryland.
2. Any party may submit evidence, examine and cross-examine witnesses and file objections, exceptions and motions; provided, however that where a party is represented by counsel, all such submission of evidence, examination and cross-examination of witnesses, and filing of objections, exceptions and motions shall be done and presented solely by such counsel.
3. The Presiding Officer, or any person designated by him for the purpose, may examine any witness called by any party. He may call as a witness any person in attendance at the hearing. Any member of the Board may examine any witness called by any party.

J. Briefs

Any party may submit briefs of the issues of fact and law involved in the hearing, which briefs shall be filed in such form, with such number of copies, and at such time as the Presiding Officer may designate.

K. The Presiding Officer may request the State Law Department to participate in any hearing as counsel for the Board; and, upon such request, said counsel shall have all of the rights with regard to the submission of evidence, examination and cross-examination of witnesses, and filing of objections, exceptions and motions as counsel for any party.

L. In the event an accused or complainant fails to appear at a hearing after due notice, the Board may reschedule the hearing, or, in its discretion, proceed upon the investigation, report, documents, witnesses and records before it.

M. All testimony taken by the Board shall be under oath. The oath shall be in the following form:

"Do you solemnly promise and affirm under the penalties of perjury that the testimony you are about to give in the matter now pending before this Board shall be the truth, the whole truth and nothing but the truth?"

N. Decision and Order

1. Every decision and order rendered by the Board shall be in writing and shall be accompanied by findings of fact and conclusions of law. The findings of fact shall consist of a con-

cise statement of the conclusions upon each contested issue of fact. A copy of the decision and order and accompanying findings and conclusions shall be delivered or mailed promptly to each party or his attorney of record.

2. If a majority of the members of the Board find the accused guilty of the violation specified in the charges, the Board shall prepare a certificate or order of revocation, suspension, or reprimand, in which case notice thereof shall be served upon the accused forthwith.
3. If the license holder is found not guilty, the Board forthwith shall order a dismissal of the charges and the exoneration of the accused, and no further action may be taken by the Board on the charges involved. Upon a finding of not guilty, the Board shall expunge the record of the proceedings.
4. The filing by the Board of a certificate or order of revocation or suspension, after due notice, hearing and findings in accordance with the procedure specified in these rules certifying that any holder of a license has been found guilty of one or more of the charges filed, shall constitute a revocation or suspension of the license to practice pharmacy in this State and/or revocation of pharmacy permit in accordance with the terms and conditions imposed by the Board and embodied in the certificate or order of revocation or suspension. If the licensee seeks review of the Board's decision pursuant to the provisions of these rules, the revocation or the period of suspension shall be stayed and shall not be effective or commence to run until final judgment has been entered in any proceeding instituted under the provisions of law or these rules and the licensee's administrative and/or judicial remedies exhausted.
5. The findings of fact, conclusions of law and order referred to in Subsection 1 of this rule shall be retained as a permanent record of the Board.
6. The Board shall not issue any license or any renewal thereof to any person whose license has been revoked or suspended by the Board except in conformity with the terms and conditions of the order of revocation or suspension, or in conformity with any order of reinstatement issued by the Board or in accordance with the final judgment in any proceeding for review.
7. Any person whose license has been revoked or suspended by the Board, or any person placed on probation under this section, may have a review of the Board's decision. Such review shall be in accordance with the provisions of Article 41, Section 206D, of the Annotated Code of Maryland, 1971 Replacement Volume.

O. Rehearings

1. Within ten days after service upon an accused of the decision of the Board, the accused may apply to the Secretary for rehearing. The application shall state the grounds for rehearing. The Board shall grant or deny said application within twenty days of its submission to the President of the Board. Application for rehearing shall stay enforcement of the Order for Revocation or Suspension until final disposition.
2. At a rehearing the Board may consider facts not presented in the original proceeding and facts arising after the time of the original proceeding. By a new order the Board may change the original order.

P. Reinstatement

When an Order of Revocation or Suspension states a time for reinstatement of license, the accused must make written request for reinstatement to the Board at the expiration of the stated time. When no time period is stated on the order, no petition for reinstatement shall be entered before the expiration of one year after date of the Order. When reinstatement is made contingent upon happening of an event, the accused must establish the occurrence of the event to the satisfaction of the Board. The form of a reinstated license shall be similar in every respect to an original license, and shall bear the new date of issue.

Cooperative Activities

The Board maintained membership in the National Association of Boards of Pharmacy. The annual meeting of the Association which was held in conjunction with the American Pharmaceutical Association was held in Houston, Texas, April 21-25, 1972. The Board was represented by President Norman Levin, Secretary Frank Block and Mr. Morris R. Yaffe. Mr. Lee Thomson, Assistant Attorney General also attended the meeting.

The Board also maintained membership in the Conference of Boards and Colleges of Pharmacy of the National Association of Boards of Pharmacy, District Number Two, comprising the states of New York, New Jersey, Pennsylvania, Delaware, Maryland, the District of Columbia, Virginia and West Virginia. The annual meeting was held in Hershey, Pennsylvania on October 14-16, 1971. Secretary Balassone was the official delegate of the Board at the meeting.

The Board maintained cooperative activities with the State Department of Health and Mental Hygiene, the School of Pharmacy—University of Maryland, the Maryland Pharmaceutical Association, the Baltimore Metropolitan Pharmaceutical Association, Federal Bureau of Narcotics and Dangerous Drugs, Food and Drug Administration, City, County and State Police.

Prescription Survey

The following table shows a survey of prescriptions filled in 1971:

PRESCRIPTION SURVEY — 1971

Baltimore City

Average Number New Prescriptions Filled in 87 out of 218 Pharmacies	15,216	
Average Number Prescriptions Refilled in 87 out of 218 Pharmacies	7,458	22,674
Average Price of Prescriptions in 87 out of 218 Pharmacies	\$3.77	
Estimated New Prescriptions Filled in 218 Pharmacies	3,317,088	
Estimated Prescriptions Refilled in 218 Pharmacies	1,625,844	4,942,932

Counties

Average Number New Prescriptions Filled in 231 out of 546 Pharmacies	18,510	
Average Number Prescriptions Refilled in 231 out of 546 Pharmacies	13,426	31,936
Average Price of Prescriptions in 231 out of 546 Pharmacies	\$3.88	
Estimated New Prescriptions Filled in 546 Pharmacies	10,106,460	
Estimated Prescriptions Refilled in 546 Pharmacies	7,330,596	17,437,056

State

Estimated New Prescriptions Filled in 764 Pharmacies	13,423,548	
Estimated Prescriptions Refilled in 764 Pharmacies	8,956,440	22,379,988

Finances

All funds of the Board of Pharmacy are deposited to the credit of the Treasurer of the State of Maryland, and disbursement covering the expenses of the Board are paid by voucher by the State Comptroller.

FINANCIAL STATEMENT — MARYLAND BOARD OF PHARMACY

1972 Fiscal Year

Budgeted	\$9,845.00
Budget Credits	58.26
Total Available	9,903.26
Expenditures	9,901.19
Unexpended Balance	2.07
Unliquidated Encumbrances	.00
Unencumbered Balance	\$ 2.07

Respectfully submitted,

Frank Block
Secretary-Treasurer
Maryland Board of Pharmacy



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Maryland Society of Hospital Pharmacists

The March 8 meeting of the Maryland Society of Hospital Pharmacists was held at Maryland General Hospital. The meeting was preceded by a dinner sponsored by Marion and Smith Kline and French Laboratories.

Program Chairman Kent T. Johnson explained the operation of the four workshops. This new innovation allowed the choice of attending three 20 minute workshops during the one hour period that the four workshops were in session. The workshops were: "Pharmacy Bulletins and Hospital Communications" chaired by Samuel Lichter and Normand Pelissier; "Pharmacy and Therapeutics Committee Decisions" chaired by Henry Derewicz; "Continuing Education within the Pharmacy Department" chaired by Kent Johnson and Clarence Fortner; and "Pharmacy Policy Statements" chaired by Dr. Peter Lamy.

The business session was called to order by President Pelissier who acknowledged the attendance of Bernard B. Lachman, President of the Maryland Pharmaceutical Association and of Nathan I. Gruz, Executive Director of MPhA and BMPA. Committee reports were given by Treasurer Harry Hamet, Program Committee Chairman Kent Johnson, Seminar Committee Chairman John Motsko, Seminar Financial Chairman Arthur Riley and Seminar Program Chairman Robert E. Snyder. President Pelissier noted that the ASHP membership campaign provided rebates to state chapters for new members joining from March 20 through November 15, 1973.

The following new members were approved for membership: Robert De Christoforo, USPHS Hospital; Morrell C. Delcher, University of Maryland Hospital; Leroy Glorioso (Associate), Hoffman La Roche; Joseph L. Johnson, III, Student Class of 1973; Charles J. Schultz, South Baltimore General Hospital; and Thomas S. Sisca, Pharm.D., Director, Clinical Services, Easton Memorial Hospital.

The Nominating Committee report was presented by Samuel Lichter, Nominating Committee Chairman. Three delegates to the ASHP Annual Meeting in Boston will be selected by mail ballot from the list of six nominees. The nominees were: Clarence Fortner, Normand Pelissier, Robert Snyder, Sydney Burgee, Mary Connelly, and Paul Burkhart. The nominations for officers for the 1973-1974 term were: President Elect: Vincent de Paul Burkhart, Ronald C. Telak; Secretary: John M. Motsko, Thomas Walker; Treasurer: Harry Hamet; Board of Directors: Clarence Fortner, Lawrence Hogue. Officers will also be selected by mail ballot. The Society Budget for 1973 was approved as presented. This concluded the official annual meeting of the Society.

The MSHP Board of Directors met after the regular meeting to discuss pending legislation with MPhA President Bernard B. Lachman and Executive Director Nathan I. Gruz.

The April 12 meeting of the Maryland Society of Hospital Pharmacists was held at the Union Memorial Hospital in Baltimore. Guest speaker was Dr. John H. Mulholland, Chief of Medicine at Union Memorial. Dr. Mulholland spoke on "Clinical Indications of Newer Antibiotics."

A motion introduced by Patrick Birmingham directed the President to express the concern of the Society to APhA President Clifton Latiolais in regards to action taken by the APhA Board of Trustees towards the American Society of Hospital Pharmacists. It was felt that the APhA, in considering the ASHP to be a "recognized" organization rather than an affiliated organization, was taking action contrary to the wishes and intent of the ASHP House of Delegates Resolution of December 3, 1972.

The following members were approved for membership: Henry L. Pelletier, Johns Hopkins Hospital; William R. Grove, U.S.P.H.S. Hospital; and David C. Hartwig, Baxter Laboratories. President Pelissier thanked Bristol Laboratories for sponsoring the meeting.

ASHP Continuing Education Programs

The following continuing education programs will be conducted by the American Society of Hospital Pharmacists during the rest of the year.

June 17-22—Institute on General Practice of Hospital Pharmacy, Cincinnati, Ohio

July 22-26—30th Annual Meeting, Boston, Massachusetts

August 5-10—Institute on General Practice of Hospital Pharmacy, Honolulu, Hawaii

September 23-26—Institute on Parenteral Admixtures and Hyperalimentation, St. Louis, Missouri

October 7-22—7th International Clinical Study Tour, Leningrad, Moscow and Munich

December 9-13—8th Annual Midyear Clinical Meeting, New Orleans, Louisiana

Gilpin Announces Appointment

Robert F. Kavan has been appointed Vice President, Operations and Computer Systems for the Henry B. Gilpin Wholesale Drug Company. Gilpin now operates in 12 states and the District of Columbia. Prior to joining Gilpin, Mr. Kavan was Executive Vice President of Ketchum Distributors, Inc. He also served with McKesson & Robbins as Vice President and Division Manager.

Gilpin also announced record sales for fiscal year 1972. The Company's sales increased by approximately 23 per cent to \$46.5 million.

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Prince Georges-Montgomery County Pharmaceutical Association

A general meeting of the PGMCPA was held on March 28 in Silver Spring, Maryland. The agenda included an audio-visual presentation on "Continuing Care Of The Ostomy Patient" narrated by Arno Hofmann, Vice President of the Higgs Company, Division of C.R. Bard Co.

Also on the agenda was state and national legislation facing the pharmacist, resumption of the Open Forum from the last meeting and nomination and election of officers for 1973-1974. The nominating slate was comprised of:

President	S. Ben Friedman
First Vice President	Henry Thies, Jr.
Second Vice President	M. Neal Jacobs
Third Vice President	Edward S. Sandel
Fourth Vice President	Leonard Rosenberg
Secretary	Paul Reznick
Associate Secretary	Edward Nussbaum
Treasurer	Stanley L. Rosen

Executive Committee

Chairman	Edward Nussbaum
1 Year Term.....	S. Zvares, J. Rose, J. McKirgan
2 Year Term —	
	Oliver Tibbs, Norman Stein, Michael Leonard
3 Year Term —	
	Robert Irby, Lawrence F. Gusman, Ralph Arline
Ex-Officio —	
	Ben S. Multz, Paul Gallagher, Henry Johnson, Herman Bloom

Upper Bay Pharmaceutical Association

Charles H. Tregoe, Chief of the Division of Drug Control for the State of Maryland, was the guest speaker at the April 4 meeting of the Upper Bay Pharmaceutical Association. The speaker's topic for the meeting held at the Bush River Yacht Club was prescription price advertising. The Upper Bay Pharmaceutical Association membership includes pharmacists from Harford and Cecil Counties and the northern portion of Baltimore County.

A.Z.O. News

Kappa Chapter of Alpha Zeta Omega Pharmaceutical Fraternity held a meeting on March 21 at the fraternity house where discussion was heard on a proposed merger with Rho Pi Phi International Pharmaceutical Fraternity. The fraternity house was also the location for "Saturday Night At The Movies" on March 24. Among the outstanding features was a film entitled "The Pharmacist" starring W. C. Fields.

The Annual Installation Banquet has been rescheduled for Sunday, June 24 at the Hunt Valley Inn, 6:00 p.m. Hot hors d'oeuvres and a fine full course dinner will be served at \$18.00 per couple. Reservations may be made by calling Dennis Klein at 484-3919.

Demino Appointed To Peoples' Post



Leonard J. Demino has been appointed Director of Professional Services for Peoples Drug Stores. Mr. Demino is a veteran of over fifteen years with Peoples Drug Stores having gone to work for them in 1956 after graduation from the George Washington University School of Pharmacy. He most recently was manager of the Georgetown store in Washington, D.C. Demino is a member of the D.C. Pharmaceutical Association.

National Poison Prevention Week

Pharmacists were featured in a number of radio and television programs during National Poison Prevention Week. In addition, editorials and news items pointed out the role of the pharmacist in poison prevention. Pharmacists throughout the state distributed poison control center telephone stickers, aspirin fliers and ipecac syrup for parents to keep on hand in case of poisoning. Henry Seidman, Chairman of BMPPA's Public Health Information Committee and Paul Freiman, President of BMPPA, requested that all pharmacists continue dispensing free one ounce Ipecac Syrup on prescription as a year round public service.

A news release from the Baltimore City Health Department pointed out that for the first time in the past five years accidental poisonings reported from 22 Baltimore hospitals and clinics show a decrease. Last year, 4,283 accidental poisoning cases were reported, a decrease of 101 cases when compared to the 1971 figures. Aspirin remained the single internal medicine that caused most accidental poisonings with 342 cases being reported from the 22 hospitals and clinics. In spite of a decrease in the overall total of reported accidental poisonings in Baltimore, drug abuse poisonings continued to rise. The Baltimore City Addict Referral and Counseling Center is located at 21 West 25th Street, telephone 366-1717.

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Obituaries

J. Albert Wolfe

J. Albert Wolfe, 88, died on March 5. He was registered by reciprocity in Maryland in 1914.

Hallie I. Toulson

Miss Hallie I. Toulson, 91, one of the first women assistant pharmacists in Maryland, died on March 31. She was the daughter of past MPhA President Milburn A. Toulson.

Sister Mary Rita Spellman

Sister Mary Rita Spellman, R.S.M., a pharmacist at Mercy Hospital for more than 40 years, died on April 22 at age 75. She was a graduate of the University of Maryland School of Pharmacy and a member of the Maryland Society of Hospital Pharmacists.

Lyndon B. Myers

Lyndon B. Myers, 62, a 1932 graduate of the University of Maryland School of Pharmacy, died on April

22. He was a member of the Maryland Pharmaceutical Association, the American Pharmaceutical Association and the National Association of Retail Druggists. He was also former president of the Carroll County Association for Retarded Children.

Handbook of Non-Prescription Drugs Available

The 1973 edition of the *Handbook of Non-Prescription Drugs* of the American Pharmaceutical Association is available for immediate order. Published by the national professional society for pharmacists, the *Handbook* has earned exceptional acceptance by pharmacists and allied health professionals since the first edition in 1967. The previous edition (1971) went through an unprecedented nine printings.

The *Handbook* is available at \$7.50 a copy from the Order Desk, American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037. Orders under \$20 must be accompanied by payment.

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Federal Budget Cuts Hurt Pharmacy Education

"The drastic cuts in the Administration's 1974 budget request for pharmacy education shows disregard for the sincere efforts pharmacy schools have made to co-operate with HEW in implementing the Health Manpower Act of 1971," according to William Skinner, Assistant Executive Secretary, American Association of Colleges of Pharmacy.

Federal capitation grants to pharmacy schools are to be cut in half for the current fiscal year and eliminated altogether in the FY 1974 budget request. "With this poor outlook, it may be necessary for schools to decrease the number of faculty members and students in order to provide quality education programs. Another alternative is, of course, to obtain additional state or private funds in order to offset the loss of Federal funds. Since the Administration does not want to honor its moral commitment to assist pharmacy and other schools, there seems to be no way the schools can honor moral commitments to students and faculty."

According to Skinner, approximately 30 per cent of the average pharmacy school budget is the Federal capitation grant. Eliminating half of this in FY 1973 and all of it in FY 1974 will mean several pharmacy schools will be forced to severely limit enrollment and research programs if other income is not found. "University administrators," he said, "have to work two to three years in advance. So, unless these budget cuts are restored, the effect will cripple many schools by the years 1974-75."

Skinner also pointed out that the initial impact of the Administration's request to eliminate new scholarships, except for students accepted into the National Health Service Corps, may keep a number of students from enrolling in first year pharmacy courses.

The University of Maryland, School of Pharmacy will lose \$130,000 in money allocated according to the number of students enrolled. A \$30,000-a-year scholarship program designed to attract minority students will be eliminated. Dean William J. Kinnard, Jr. does not foresee reductions in either students or faculty but the school will be prevented from further expansion over the next two or three years.

In The News...

CLARENCE L. ANSTINE, sales representative for Eli Lilly and Company, has been named Atlanta, Georgia, Area Manager of Dista Products Company, a new pharmaceutical marketing division of Eli Lilly. Mr. Anstine is a registered pharmacist in Maryland and is a member of the Maryland Society of Hospital Pharmacists and Phi Delta Chi, professional pharmacy fraternity. JAMES C. DAVIS, of F. A. Davis & Sons, Baltimore, has been elected to a 1-year term as Vice President of the National

Association of Tobacco Distributors at the Association's Las Vegas convention. DR. SIDNEY WOLFE, physician and Director of the Health Research Group (an arm of the Nader organization) spoke at a recent pharmacy administration seminar on "Pharmacy Student Input Into the Consumer Movement." MARTIN REIN, New York state community pharmacist, has been selected to receive the Daniel B. Smith Award of the APhA Academy of General Practice of Pharmacy.

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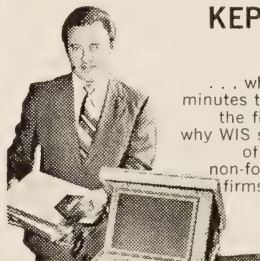
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the maryland pharmacist

MAY
1973
Volume 49
Number 5

Editorial—Differential Pricing

Mechanisms of Drug Interactions

by Gary G. Buterbaugh, Ph.D.

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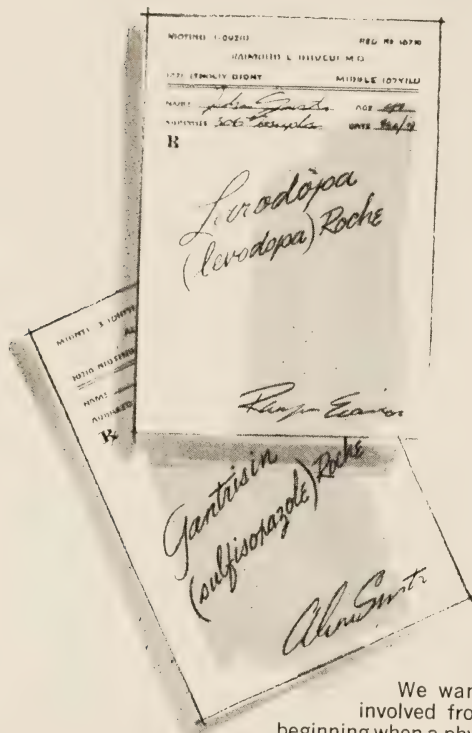
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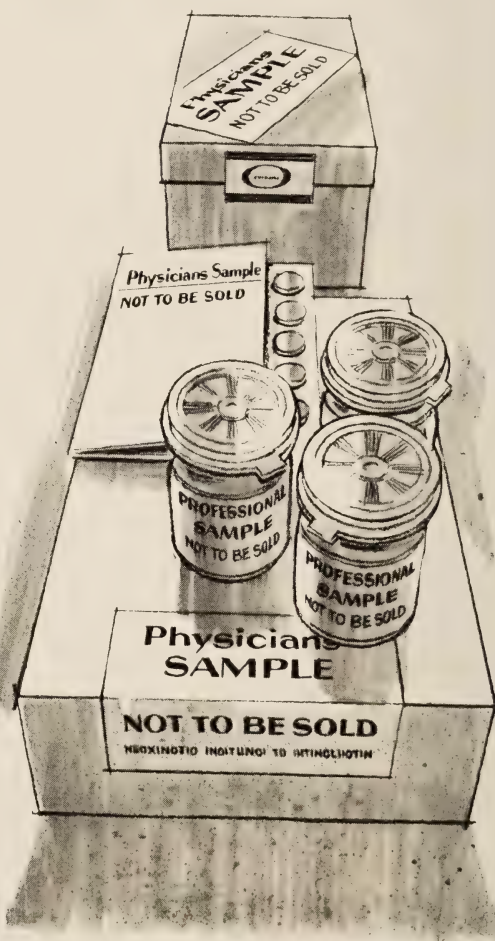
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HERMAN J. BLOOM, *Photographer*

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MAY 1973

NUMBER 5

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Editorial . . .

Differential Pricing

We thought that federal law was "crystal clear," that pharmaceutical manufacturers could not discriminate in the prices charged to various customers.

We thought that manufacturers had to publicly announce to all buyers the requirements of quantity purchases and all would be treated equally.

We thought that *all* customers had to be offered *any* and *every* deal.

Every day we hear of certain discounters and giant corporations being offered special prices, free goods, and under-the-counter deals.

We hear of sales representatives and "detail" men who unload free goods and samples from their trunk in order to induce pharmacies to purchase their brand of ampicillin and other competitive drug products.

Here is another reason why "drug product selection" by the pharmacist is necessary in order for *all* pharmacists to dispense the quality drug product that can be purchased legitimately at a reasonable price.

The manufacturers who are guilty of discriminatory and underhanded distribution and marketing cater to pharmacies that attempt to appeal for patronage solely on price. The pharmacies that are operated by pharmacists who emphasize professional service, patient medication record cards, personalized service, and close physician-patient-pharmacist relations are made to look like exploiters of the public.

It is time for manufacturers to stop playing with the fate of pharmacists who are trying to provide pharmaceutical services of high standards at a fair charge to the patient and an equitable fee to the pharmacist.

Pharmaceutical manufacturers who play the game straight must help pharmacists and their associations to cleanse the pharmaceutical complex from these unscrupulous manipulators. The sad alternative will be more governmental intervention.

Let's clean house together immediately before it's too late!

—Nathan I. Gruz

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A Preview of Community Pharmacy 1972

The preliminary *Lilly Digest* report of 1,008 community pharmacy operations (about half of the total *Lilly Digest* sample) shows that 1972 was marked by rising expenses and falling profit. When the individual income and expense statement items are expressed as percentages of total sales and compared with 1971 *Lilly Digest* data, they indicate that—

The cost of goods sold dropped substantially during the year, but total expenses increased markedly with the result that net profit fell during 1972 to an all-time low.

Total sales reached a record high of \$250,089 and reflected an increase of \$13,485 (5.7%) over 1971 sales. This total dollar gain was due to an upswing in prescription revenue of 9.3 percent and an increase of 2.8 percent in other sales. During 1972, prescription sales as a percent of total sales climbed to 46.3 percent (up from 44.7 percent in 1971). This continues a long-standing upward trend in prescription revenue as a percent of total sales.

The number of prescriptions dispensed during the year rose to 26,536—an increase of 1,414 prescriptions. Of this total, 46.3 percent were new prescriptions. Refills provided 53.7 percent of the total prescription activity. The average prescription charge went up fifteen cents during 1972 from \$4.21 to \$4.36—up 3.6 percent.

Total operating expenses increased by 8.2 percent and thus set a new high at 32.7 percent of total sales. Net profit fell to 3.6 percent in the face of escalating expenses—notably employees' wages. Employees' wages rose almost 6 percent over the 1971 figure and now stand at 12.1 percent of sales. Total income (salary plus net profit, before taxes) established a record high of \$29,999 per pharmacy-owner.

The inventory level rose in dollars and as a percent of sales. The sales productivity of the prescription department inventory reached an all-time high of \$8.07 per stock dollar, whereas other merchandise returned \$4.69, a slight decrease in comparison with the 1971 figures. The annual *Lilly Digest* will be completed and distributed early in September, 1973.

Wanted — Pharmacist Recipes

Favorite recipes of American Pharmacists are solicited by Richard Strommen, former Executive Director of the Illinois Pharmaceutical Association. Strommen is compiling a "Pharmacist's Cook Book" and would appreciate your sending him your favorite indoor and outdoor recipes. Please mail yours to Richard Strommen, 300 North State St., Apt. 5211, Chicago, Illinois 60610.

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MPhA In Action

Board of Trustees Meetings

NATHAN I. GRUZ, *Executive Director*

April 5, 1973

The following is a summary of actions taken at the April 5, 1973 meeting of the Board of Trustees:

- Noted receipt of letter from Maryland Society of Hospital Pharmacists listing members for joint committee with MPhA.
- Noted correspondence from APhA on control of Methaqualone.
- Approved President's report noting the demands of the busy legislative session. Reported on progress of Drug Product Selection Law formulary which is to be released with listing of antibiotics as first category. Also reported on attendance at MSHP meeting with Executive Director and noted that MPhA and MSHP were working in closer relations which hopefully will result in one strong association.

Board Chairman noted favorable results of Board meeting in Annapolis with visitation to legislators.

- Approved Treasurer's report.
- The Executive Director's priority concerned legislative matters: attendance at many hearings, preparation of testimony and monitoring of legislation. Noted considerable problems concerning prescription promotion. Reported on meetings with representatives of E. R. Squibb who provided reference material and slides for talks on drug abuse. Attended premier showing of film on drug addiction written by Dr. John C. Kranz, Jr. Other activities included meetings on third-party plans, Medicaid, Alumni Association meeting addressed by Dr. Louis Kaplan, Chairman of University of Maryland Board of Regents, and meetings with MSHP and BIPA Committees.
- Approved action for clarification by State Health Department on delay of release of VD Task Force report.
- Received School of Pharmacy report from the Dean. There are three times as many applicants as openings for September, 1973.
- Approved Membership Committee report. The Director noted that APhA did not adopt a request by some affiliated states for a moratorium on reciprocal membership.
- Approved Prescription Insurance Plans Committee report stressing meeting with state officials regarding Medicaid problems: error bills, definition of acquisition cost and utilization controls. Mr. Rubin is compiling a chart on the details of various third-party programs and an effort will be made to get them to inform MPhA before soliciting pharmacies.

- Received Legislative Committee report noting that no undesirable legislation had passed to date. A complete report will be made after the session when the complete list of signed bills is available.
- Heard Report of Meeting of Board of Pharmacy. Approved motion recommending Board of Pharmacy to seek regulation or law prohibiting prescription forms with pre-printed drug product name. Also referred matter to State Medical Society.
- Discussed coded marking of pharmacy inventory to assist in investigations of robberies and illegal distribution.
- Speaker of MPhA House of Delegates outlined agenda for meeting of April 26.
- Approved furnishing MPhA members with forms for notifying prescribers in reference to the Drug Product Selection Law.
- Unanimously elected Honorary Life Trustee Simon Solomon as "Life Member" of MPhA.
- Discussed the killing of Pharmacist Herman Bretler and other crimes against pharmacists. Approved support of House Bill declaring assaults and robberies of pharmacists a federal crime.
- Approved expenditure of sum of \$250 as pledge to the Herman Bretler Fund for reward for information leading to the arrest and conviction of those responsible for his death.

New Members

The following is a list of new members approved at the April 5, 1973 meeting of the Board of Trustees of the Maryland Pharmaceutical Association:

Patrick H. Birmingham, Baltimore, Good Samaritan Hospital
Linda S. Craig, Baltimore, Johns Hopkins Hospital
John M. Deboy, Ellicott City
Robert J. Kertman, Upper Marlboro
Lyndon B. Myers, Mt. Airy (Deceased April 22, 1973)

PHARMACY CALENDAR

July 21-27—American Pharmaceutical Association Annual Meeting, Boston, Massachusetts.

December 9-13—American Society of Hospital Pharmacists Midyear Clinical Meeting, New Orleans, Louisiana.



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Program Highlights

91st ANNUAL CONVENTION

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June 29 - 30, July 1, 1973

Hunt Valley Inn, Cockeysville, Maryland

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Friday, June 29.

Registration—Desk Open 1-5 p.m.

Golf Tournament

Tennis Tournament

Swimming

Evening: Limestone Dinner Theater Party
6 p.m. Cocktails 7 p.m. Dinner

Saturday, June 30.

8:00 a.m. Registration Desk Opens

8:00 a.m. Breakfast Meeting for Officers and Board Members of MPhA and Local Affiliated Associations

9:30 a.m.—House of Delegates Meeting. All members invited.

President's Report

Report of Executive Director

Committee Reports

Report of School of Pharmacy

New Business

10:30 a.m. LAMPA 20th Anniversary Meeting — Ladies' Auxiliary of MPhA

10:30 a.m. TAMPA Meeting — Travelers Auxiliary of MPhA

12:00 noon Luncheon—MPhA—TAMPA—LAMPA
Feature: Dr. William S. Appel, Executive Director, American Pharmaceutical Association, in a "Meet the Press Format"—Not a speech. Dr. Appel will field all your questions about pharmacy, APhA, etc.

2:00 p.m. Joint MPhA—APhA Academy of General Practice Program: "The Pharmacist and the Consumer"—A Professional Experiences Workshop Program. A newly-developed series of dramatized vignettes using slide-tape recordings media to explore pharmacist-patient relationships as

related to the "consumer movement." Workshop participants will confront situations in on-going discussions.

2:00 p.m. LAMPA—"Chinese Cookery" Talk and demonstration. Mrs. Catherine Chen. Souvenirs.

Adjournment 4:30 p.m.

Evening Entertainment. Registration Open—8 p.m.

9:00 p.m. Presidential Reception: Orchestra and dancing for all registrants. Cocktails hosted by Youngs Drug Product Corporation

Sunday, July 1.

9:00 a.m. Registration Open

9:30 a.m. House of Delegates—Second Session
Open to all members.

Business Session

Report of Maryland Board of Pharmacy
Election of Officers

Election of Nominees to Board of Pharmacy

Adjournment upon conclusion of sessions.

1:30 p.m. LAMPA—Trip to Oriental Gardens at Breezewood Estate at nearby Monkton.

Evening Entertainment—Registration, 6:00 p.m.

6:30 p.m. Cocktail Hours. Sponsored by MPhA Sustaining Members: Borden-Hendler, Calvert Drug, F. A. Davis, H. B. Gilpin, Loewy Drug, Maryland News, and Miller Drug Sundry.

7:30 p.m. Banquet
Installation of officers, MPhA and LAMPA.

Introduction of TAMPA Officers.
Presentation of Bowl of Hygieia Award for Community Service to Paul Reznick.

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Mechanisms of Drug Interactions

by Gary G. Buterbaugh, Ph.D., Assistant Professor,
Department of Pharmacology and Toxicology,
University of Maryland, School of Pharmacy

DRUG INTERACTIONS INVOLVING DIPHENYLHYDANTOIN (Dilantin[®])

Diphenylhydantoin (DPH) is considered by many physicians to be the drug of choice for the treatment of most forms of epilepsy with the exception of petit mal and it is considered to be a relatively safe drug to use. However, adequate seizure control demands that DPH be administered chronically, often for many years. This long-term therapy presents the potential for interactions between DPH and other drugs the patient may receive.

The most frequently reported cause for interactions involving DPH is the alteration of DPH plasma concentration after another drug has been added to the regimen. These changes are usually due to alterations in the rate of liver microsomal metabolism of DPH. DPH is only slightly water soluble so the elimination of unmetabolized drug is very small and most is excreted as water-soluble metabolites. Therefore, drugs which inhibit or induce DPH metabolizing enzymes would be expected to cause an elevation or reduction of DPH plasma levels, respectively.

Many drugs have demonstrated the capability of increasing DPH plasma levels and/or prolonging the half-life of DPH in man. The antitubercular drugs isoniazid (*Nydrazid*) and p-aminosalicylic acid (*PAS*) cause a rapid and large increase in DPH plasma concentration to toxic levels (1). These two drugs are also synergistic in their effects to inhibit DPH metabolism and increase DPH plasma levels (2). This interaction is complicated by the fact that isoniazid metabolism in man is genetically controlled; 10-20% of the population are slow isoniazid metabolizers. These are the patients who are most susceptible to this interaction since they maintain high plasma isoniazid concentrations.

Other drugs that have deserved clinical reports of elevating DPH plasma levels include bishydroxycoumarin (*Dicoumarol*) (3) and related anticoagulants, phenylramidol (*Analexin*) (4), disulfiram (*Antabuse*) (5), methylphenidate (*Ritalin*) (6), diazepam (*Valium*) (7), chlor-diazepoxide (*Librium*) (7), and propoxyphene (*Darvon*) (8). These interactions with DPH are also attributed to inhibition of DPH metabolism.

Phenobarbital deserves special mention since it is often used to maintain control of seizures in epileptic patients. Low doses of phenobarbital, by inducing hepatic enzyme systems, may cause a decrease in DPH plasma levels. However, higher doses of phenobarbital will compete with DPH for the same hepatic enzyme systems and will elevate DPH plasma levels. Often these two effects of phenobarbital will counterbalance and the net effect on DPH plasma levels is of small clinical significance.

Drugs other than phenobarbital have the capacity to lower plasma levels or shorten the half-life of DPH. One of the most important is ethanol which has variable effects on DPH plasma levels but will shorten the half-life of DPH, necessitating more frequent dosing (9). The mechanism of this interaction has not been established.

The clinical significance of elevated DPH plasma levels by other drugs is variable and need not be detrimental. Low, ineffective plasma levels may be elevated into a higher but non-toxic range and improve seizure control. However, effective plasma levels may be elevated to a toxic range. In this case, the offending drug can be discontinued, or, if it must be continued (i.e. isoniazid), an adjustment of DPH dosage is needed. Monitoring the DPH plasma level will facilitate this adjustment but it must be remembered that the relationship between DPH plasma level and therapeutic efficacy is extremely variable and must usually be determined for each patient.

Alteration of the plasma concentration of other drugs may be secondary to the administration of DPH. DPH has been reported to lower the plasma level of digitoxin, bishydroxycoumarin (*Dicoumarol*) and phenobarbital and the dosage of these drugs must be adjusted accordingly (10). DPH, by inducing hepatic enzyme systems, may also cause rapid metabolism of endogenous adrenalcorticosteroids or synthetic steroids such as dexamethasone (*Decadron*) (10).

Finally, recent evidence suggests that DPH accelerates the conversion of vitamin D to inactive and water-soluble metabolites instead of the active 25-hydroxycholecalciferol metabolite. This would increase the requirements for vitamin D in epileptic patients receiving DPH.

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Baltimore Metropolitan Pharmaceutical Association

PAUL FREIMAN

Paul Freiman, President of the Baltimore Metropolitan Pharmaceutical Association, graduated from the University of Maryland, School of Pharmacy in 1953. He served two years in the Merchant Marine and two years in the U.S. Army. In 1960, he was elected to a two year term as Director of A.Z.O. Pharmaceutical Fraternity and served on the National Board of Directors of A.Z.O. from 1962-1964. From 1966 to 1969 he chaired the Swain Seminar of the Maryland Pharmaceutical Association and was chairman of the first continuing education program for pharmacy in Maryland in 1968.

He was an instructor at the University of Maryland, School of Pharmacy in 1969 and received the A.Z.O. Order of the Double Star in 1970. He was MPhA's Chairman of the V.D. Awareness Campaign in 1970 and was a member of the Maryland State V.D. Task Force in 1971. He has been Chairman of the MPhA Legislative Committee from 1971 to 1973 and a Captain in the Heart Fund 1969-1971.

A partner in the Security Pharmacy, he is presently a member of the Maryland State Formulary Committee, the MPhA Board of Trustees and is a member of the Beth Israel Synagogue. He is married to the former Phyllis Nechamkin and the Freimans have two daughters and one son.

Installation Speech

by Paul Freiman

Presented before the Baltimore Metropolitan Pharmaceutical Association, Blue Crest North, January 28, 1973.

Pharmacy today has many problems; but as long as I can remember we have always had problems. One of the most challenging aspects of being involved in Association work is the fact that our profession is always being attacked and that we must constantly be defending ourselves. However, now is the time for Pharmacy to take the initiative and inform the public what we stand for. Now is the time to ask some questions. We must ask, "What better serves the public's interest—just counting and pouring of medication, or the maintenance of patient profile systems to prevent dangerous drug interactions and drug allergic reactions?" We must ask, "What better serves the public interest—just counting and pouring or the taking of our time and money for continuing education participation to keep up with the latest trends in pharmaceutical and medical sciences so that we can better serve the public and the medical profession?"

We must ask—"What better serves the public's interest—just counting and pouring or taking the time to talk to the patient, to advise him of possible side effects, and to counsel him, not only on prescriptions, but on over-the-counter medications as well?" And we must ask, "What better serves the public's interest—to offer a 10 per cent discount to those over 60 (or as one chain does—those under 6) or to take a genuine interest in the health and welfare of not only our elder citizens, but of all the people we serve." I think the answers are obvious to those gathered here. However, the answers have never been told to the public; and this, I hope, will be one of the goals of this Association for the coming year. We must tell the public that proper pharmaceutical services are important to their health and far outweigh the cost of the prescription.

In order to accomplish this, I have appointed Henry Seidman as chairman of a Pharmacy Public Information Committee. The avowed purpose will be to tell our story to the public—to inform the public that people should be as careful in choosing a pharmacy and pharmacist as they are careful in choosing a physician. We want all to know that in the course of a pharmacist-patient relationship a person's pharmacist can save his life, or at the very least, save him or a member of his family a great deal of discomfort. I think that any pharmacist who keeps patient record cards will attest to this fact for we have experienced it many times over.

We have suggested to the Maryland Pharmaceutical Association that a Pharmacy Consumer Advocate Committee be formed on a statewide basis. We feel that Pharmacy can serve the public not only professionally, but economically as well. We feel that we can be as effective in saving them money on the cost of their prescriptions as any advertising law that may or may not be in effect. I think that our efforts on behalf of the Drug Product Selection Law show what our profession can do in the public interest. And with the assurance that a formulary will soon be released and with the changes that we contemplate in the legislature this year, hopefully there will soon be an effective means of saving the public money. There are many other areas in which this committee can serve, such as asking our members to remove from sale worthless OTC products that do little more than take the public's money without offering anything in return. This committee can protest mergers such as we saw in the past year that resulted in exchange of brand names between companies and again costing the public money with little in return. There are many other areas where this committee can serve the public and hopefully the MPhA will be quick to organize it and make it effective.

I have designated Ronald Lubman and Irvin Kamenetz to co-chair a health planning committee whose pur-

pose will be to maintain our consistent interest in the distribution of proper pharmaceutical services. And I have asked them to contact the Mayor and County Executive and advise them that our expertise is available in any areas effecting the health of their citizens.

John Padousis and Mark Levy will head our membership committee. I would like them to concentrate not only on renewing membership of pharmacy owners, but increasing our membership of employee pharmacists. We hope that in the near future, employee pharmacists will realize that even though they are not store owners, what we in the Association do to elevate the status of the Pharmacist as a professional, ultimately effects their livelihood. We want their voices and their ideas to be heard in our association and more than welcome them into membership.

Naturally, Charles Spigelmire will continue on as Public Relations Committee Chairman, to tell the public how pharmacists are constantly working for them in the areas of public health. And Melvin Rubin will again serve as Program Chairman, to help develop programs to entice our membership to attend meetings and remain the best informed pharmacists in our state.

I have presented a program: whether it will be effective depends greatly on the general membership, my committee chairmen, my officers, my executive committee, and finally on my performance as your president.

I would like to thank you for the privilege of serving as your president. I would like to thank Nathan Gruz, who has helped me so much in the past and hopefully in the future. To Melvin Rubin, I give a special thanks for his yeoman work for the success of this banquet. Most important of all, I thank my lovely wife, who has endured so much with me in the past and continues to be a great source of courage to me.

In conclusion, I would like to say, that perhaps one of the most distressing things I found when we were first discussing the Drug Product Selection Bill was the quickness of many of our colleagues to say that other pharmacists were not to be trusted. That is, they would buy the cheapest and sell for the most. I have never heard a physician say that he should be denied the right to prescribe certain drugs because a few physicians are abusing the privilege. I have never heard a lawyer say that he should be denied the right to handle certain cases because a minority might abuse the privilege. And yet we find so many of our members willing to deny themselves and others the prerogatives of their profession because of a few that might abuse the privilege.

I must take poetic license with an old Johnny Mercer song that went "We must accentuate the positive"—the positiveness that pharmacy is a profession whose purpose is to protect the public health and welfare. "Eliminate the negative"—the negativeness of those few who would use their rights as professionals to violate a trust and practice Pharmacy for the privilege of profit alone. "Don't mess with Mr. In-between"—the mediocrity of poor or little professional service strictly on the basis of how fast,

how many, or how much. And out of context—"Latch on to the affirmative."—the affirmation that if we believe in ourselves and our profession then, it should be relatively easy to have the public believe in Pharmacy also.

General Meeting

A general meeting of the Baltimore Metropolitan Pharmaceutical Association was held on March 22, 1973 at the Quality Inn Motel on Reisterstown Road at 9:00 p.m. President Paul Freiman opened the meeting and introduced Mr. Bailey Hutman of the Public Service Leasing Company who explained the Maryland Pharmaceutical Association Car Leasing Program.

President Freiman reported on the BMPA Executive Committee meeting and announced that an appropriation was made to the MPhA for additional staff to assist in public information activities. The objective is to concentrate programs on the role of the pharmacist in protecting the health of patients through services such as patient medication records. He spoke on the article in *The Sun* in which he was interviewed on the contribution of patient record cards in preventing injury through drug interactions. There was favorable response from the public. Mention was also made of a Time Magazine article on the same subject.

Mr. Freiman announced that he had appointed Harry Seidman as Chairman of a newly-formed Pharmacy Public Information Committee. An Employee Committee under the chairmanship of Dennis Klein was formed. The Committee is comprised of representatives of each major chain as well as independent pharmacies.

Executive Director, Nathan I. Gruz, reported on Annapolis activity outlining the status of several bills affecting pharmacy. Several pharmacists indicated there had been difficulties in receiving payment for East Baltimore Medical Plan prescriptions and it was announced that these prescriptions should be directed to Pharmacist Sue Fine, State Department of Health and Mental Hygiene.

Public Relations Chairman Charles Spigelmire introduced Claude Nogay, Chairman of the School of Pharmacy's Student Committee on Drug Abuse Education (SCODAE). Mr. Nogay thanked the BMPA and MPhA for their subsidies towards the work of his committee. These funds will enable SCODAE's bulletin, *Pharmalert*, to be sent to all pharmacies. Charles Spigelmire described BMPA activities during Poison Prevention Week. Joseph U. Dorsch, Chairman of the Executive Committee, presented the Executive Committee report noting that substantial funds had been allocated for extra office staff. Melvin Rubin, Chairman, reported on activities of MPhA's Medicaid Committee. He noted that the State has agreed to process error bills sooner and will discontinue the practice of issuing temporary Medicaid cards.

He reported on possible changes in the definition of "wholesale cost." The entire Medicaid Program will be

reviewed by the committee to develop a program for savings and to achieve realistic fee policies.

Norman Steinberg of the Mayer and Steinberg Insurance firm explained the difference between malpractice insurance and "druggists' liability" insurance. A group workman's compensation policy is also available through MPhA.

Mr. Gruz reviewed the current status of the National Pharmacy Insurance Council. He also commented on nursing home corporation ownership of pharmacies. Melvin Rubin reported on the progress of the Formulary Committee for Drug Product Selection. An antibiotic list will soon be released. Pre-convention Trip Chairman Alder Simon reported on the Spain trip.

A brief question and answer session followed.

Other topics discussed were: The "Drug Product Selection form," status of out-of-state prescriptions, Local 355 Prescription Plan, telephone requests for copies by pharmacists, Blue Cross and other drug programs.

Mr. Spigelmire stressed the importance of PHARM-PAC (The Pharmacists Political Action Committee) and requested all to contribute at this time.

Prince Georges-Montgomery County Pharmaceutical Association

The PGMCPA officers for the coming year were installed on May 6 at the Golden Bull Inn in Adelphi, Maryland. Master of Ceremonies and entertainer for the evening was Douglas Llewelyn of station WTOP. Congressman Gilbert Gude spoke on current legislation concerning Pharmacy. S. Ben Friedman was installed as President.

A.Z.O. News

Kappa Chapter of Alpha Zeta Omega Pharmaceutical Fraternity met on April 18 to hear regional reports, the Nominations Committee report and to view an educational film. On May 23, election of officers for the coming year was held. The following slate was presented by the Nominations Committee: Directorum, Jerry Cohen; Sub Directorum, Alan Stoff; Under Graduate Sub Directorum, Les Benson; Excheque, Dennis Klein; Signare, Mark Levi; Corresponding Signare, Arnold Honkofsky; Bellarum, Arnold Kaplan; Executive Unit, Irving Bergofsky.

Films entitled "The Triad of Infection" and "The Penetrating Eye" were shown courtesy of Eli Lilly and Co. The Annual Installation Banquet will be held at the Hunt Valley Inn on June 24, 1973.

Maryland Board of Pharmacy News

Pharmacy Changes

The following are the pharmacy changes for the month of April:

New Pharmacies

Revco Drug Center, Sidney Dworkin, President; U.S. 40 and Waverly Drive, Frederick, Maryland 21701.

Drug Fair No. 89, Milton L. Elsberg, President; 3233 Brinkley Road, Temple Hills, Maryland 20031.

No Longer Operating As Pharmacies

R. R. Smith Pharmacy, Rudolph M. J. Smith, 108 Main Street, Annapolis, Maryland 21401.

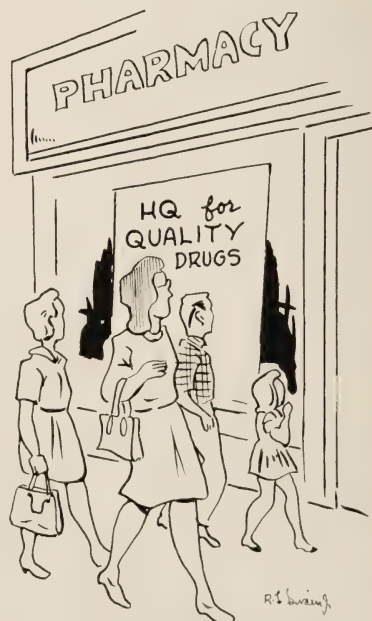
Thomas and Thompson Company, John B. Thomas, III, President; 101-103 East Baltimore Street, Baltimore, Maryland 21202.

Changes of Ownership, Address

Homeland Pharmacy, Joseph Loetell, Jr., President (Change of ownership); 5306 York Road, Baltimore, Maryland 21212.

Overbeck Pharmacy, Jerry L. Overbeck, President; (Change of ownership and pharmacy name—was Bambrick's Pharmacy); 638 Race Street, Cambridge, Maryland 21613.

Medical Center Pharmacy of Rockville, David C. Healy, President (Change of ownership); 809 Viers Mill Road, Rockville, Maryland 20851.



WHAT THE PUBLIC LIKES

V.D. prevention news

10 MILLIONTH "PLAIN TALK" V.D. PAMPHLET DISTRIBUTED

With V.D. on the climb throughout the world, it's comforting to note that the public is really getting the word on how to aid in its prevention. To date, Youngs



Here Mel Clark (left) Sales Manager, Youngs Drug Products Corp., presents 10 Millionth Pamphlet entitled "Plain Talk About V.D." to Virginia Governor Linwood Holton on the occasion of State's special "V.D. Awareness Month." Looking on are Thomas W. Rorer, President VPhA and Richard B. Lake, Chairman of Public Affairs Commission.

has printed and distributed over 10 million copies of the informative booklet entitled "Plain Talk About V.D."

ANOTHER YOUNGS ADVERTISING FIRST

In 1968 Youngs Drug Products Corporation created history as a prophylactic company by pioneering the first condom ad ever to run in a consumer magazine. And now they've done it again! In late 1972 and 1973

Youngs is sponsoring the first condom radio commercials ever to be aired in the U.S. A saturation program starting with a series of three, thirty-second prime drive time spots will be run on Black radio station WNJR. WNJR's New York and New Jersey market represents an audience of 1¾ million listeners to make up a lucrative market of over one billion

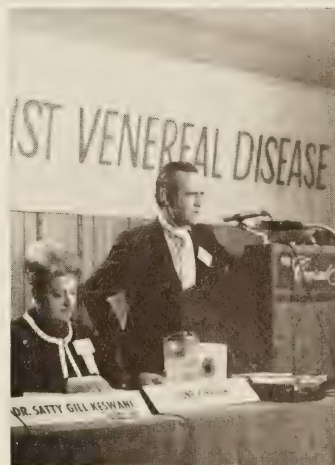


dollars annually. The cleverly written radio dialogue drives home the point that listeners should visit their pharmacist and ask for TROJANS, the number one drug-store brand.

NATIONWIDE "WOMAN'S WAR" WAGED AGAINST V.D.

Nearly 500 women members of WONARD (Women's Organization of NARD) convened in Chicago at the NARD Convention to organize a War on Venereal Disease. The new WONARD campaign will stress PREVENTION as the single, most important method to combat the nation's most serious

epidemic illness. Guest speakers at the V.D. symposium included Frank Santora, Chief of V.D. Information, New York City Department of Public Health, Dr. Satty Gill Keswani, India-born gynecologist and a specialist in the problem of infertility, Stephanie D. Radford, registered pharmacist from Washington State, and John C. MacFarlane (pictured above) president of Youngs Drug Products Corporation.



The importance of the meeting was attested by the fact that the three major TV news networks, ABC, CBS, and NBC covered the proceedings along with local Chicago TV and newspapers. One of the revealing facts that came up at the convention was that the nation's 130,000 pharmacists now comprise the most active organized bloc fighting venereal disease.

Francis S. Balassone Memorial Lecture Hall Dedicated

Francis S. Balassone, former Secretary of the Board of Pharmacy and Chief, Division of Drug Control, who died unexpectedly at his home on January 2, 1972, was remembered by his relatives and friends at a special dedication ceremony of the Francis S. Balassone Memorial Lecture Hall on April 25, 1973.

Among those participating in the dedication ceremonies were: Neil Solomon, M.D., Ph.D., Secretary, Maryland Department of Health and Mental Hygiene; Dr. Albin O. Kuhn, Chancellor, University of Maryland at Baltimore; Dr. William J. Kinnard, Jr., Dean, School

of Pharmacy; Mr. Henry G. Seidman, Chairman, Francis S. Balassone Memorial Lecture Hall Dedication Committee; and Mr. H. Nelson Warfield, Past President of the School of Pharmacy Alumni Association.

After each speaker on the program reviewed his relationship with Mr. Balassone and related anecdotes regarding various aspects of his life, Mrs. Balassone proceeded with the unveiling of the memorial plaque which will be located at the entrance to the lecture hall.

A tour of the Allied Health Professions Building and a reception followed the ceremonies.



Dedication ceremonies for the Francis S. Balassone Memorial Lecture Hall. Top photo: Dean William J. Kinnard, Jr. of the University of Maryland, School of Pharmacy and Mrs. Francis S. Balassone. Lower photo: Henry G. Seidman presents remarks at the podium. Other participants include (l to r) Dr. C. T. Ichniowski, Assistant Dean, University of Maryland, School of Pharmacy; Mrs. Francis S. Balassone;

H. Nelson Warfield, Past President, Alumni Association, University of Maryland, School of Pharmacy; Dean William J. Kinnard, Jr.; Dr. Albin O. Kuhn, Chancellor, University of Maryland at Baltimore; Julian Morgan, Administrative Assistant to the Dean, University of Maryland, School of Pharmacy; and Neil Solomon, M.D., Ph.D., Secretary, Maryland Department of Health and Mental Hygiene.

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Pharmacy in the News



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MPhA Spring Regional and House of Delegates Meeting, Friendship International Hotel, April 26, 1973: (1 to r) Henry G. Seidman, Speaker, MPhA House of Delegates; Delegate Steven V. Sklar (Baltimore City—5th), Author and Chief Sponsor of the "Maryland Comprehensive Drug Abuse Control and Rehabilitation Act of 1969" and luncheon speaker; Bernard B. Lachman, MPhA President; and Nathan I. Gruz, Executive Director, MPhA and BMPA.

The Ladies Auxiliary of the Maryland Pharmaceutical Association held a special program featuring television personality Stu Kerr (center) of WMAR-TV. Also shown are (1 to r) Mrs. Charles S. Austin, Treasurer; Mrs. Louis M. Rochman, President, Mrs. Richard R. Crane, Communications Secretary; and Mrs. Manuel B. Wagner, Membership Treasurer.



— Photo by Paramount Photo Service

Chairman of Bonds for Israel in Annapolis, MPhA Past President Nathan Schwartz (center) and Mrs. Schwartz with former Premier David Ben Gurion. The group meeting with the 86 year old statesman was the highlight of an 8 day visit.

The Baltimore Bonds for Israel Delegation met with Haim Bar Lev, Israeli Minister of Commerce and Industry, in Jerusalem. (L to R) Mrs. Nathan Schwartz, Nathan Schwartz, Past President, MPhA; General Bar Lev, formerly Army Chief of Staff, Martin R. Resnick, Chairman, Baltimore Israel Bond New Leadership Division, who led the delegation, and Mrs. Resnick.

—Israel Bond Photo by Ilant



MPhA PUBLIC RELATIONS

Charles E. Spigelmire (right), MPhA Public Relations chairman and host of the weekly radio program "Your Best Neighbor" with his guest, MPhA President Bernard B. Lachman, discussing Poison Prevention Week.



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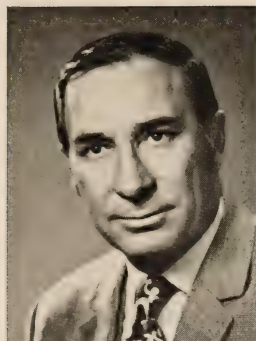
Alumni Association Dinner



— Photo by Paramount Photo Service

University of Maryland School of Pharmacy Alumni Association Dinner, Valley Country Club, Towson, March 28, 1973. Counterclockwise from upper left: Dr. Albin O. Kuhn, Chancellor, University of Maryland at Baltimore, and Mrs. Kuhn; Mrs. Dolores Kinnard and Dean William J. Kinnard, University of Maryland, School of Pharmacy; Colonel J. Logan Schutz, Director of Alumni Affairs, Uni-

versity of Maryland, and Mrs. Schutz; Mrs. Goldstein and Samuel A. Goldstein, Banquet Arrangements; Mr. Ronald A. Sanford, President, University of Maryland School of Pharmacy Alumni Association and Mrs. Sanford; and Guest Speaker, Dr. Louis L. Kaplan, Chairman, University of Maryland Board of Regents.



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Pharmacists Attend Crime Seminar

A group of Baltimore City area pharmacists attended the 2nd annual Small Business Crime Seminar presented on May 1 at the new Police Headquarters Building Auditorium in Baltimore. The seminar was preceded by a guided tour of the new police building. Of most interest to the group were the chemical laboratory section, the communications center, and the fingerprint identification areas.

Speakers included Deputy Police Commissioner Ralph G. Murdy; Judge Solomon Liss, Supreme Bench of Baltimore City; Joseph Koutz, Assistant State's Attorney for Baltimore City; Sergeant Joseph McMann, Bad Checks Squad and Lt. Francis Reidy, Crime Control Teams.

The Seminar is sponsored by the Mayor's Advisory Committee on Small Business and the Baltimore City Police Department, in cooperation with the Affiliated Merchants, Inc. and the Baltimore Association of Insurance Agents, Inc. Ronald A. Lubman, Vice President of BIPA, is a member of the Mayor's Advisory Committee on Small Business.

The trend in lung cancer deaths in Baltimore City is upward. The 1972 deaths totaled 494. This may be compared with 322 in 1961, 195 in 1951 and 45 in 1931. Of those who died last year, 403 were male and 91 female.

Obituaries

Walter M. Frazier

Walter M. Frazier, a Past President of the American Society of Hospital Pharmacists, passed away in Cincinnati, Ohio on April 21. He was 63 years old.

Frazier was a charter member of the American Society of Hospital Pharmacists and received the Harvey A. K. Whitney Lecture Award, American hospital pharmacy's highest honor, in 1958.

Nathan Keren

Nathan Keren, 65, former hospital pharmacist who retired in 1971, died on April 22.

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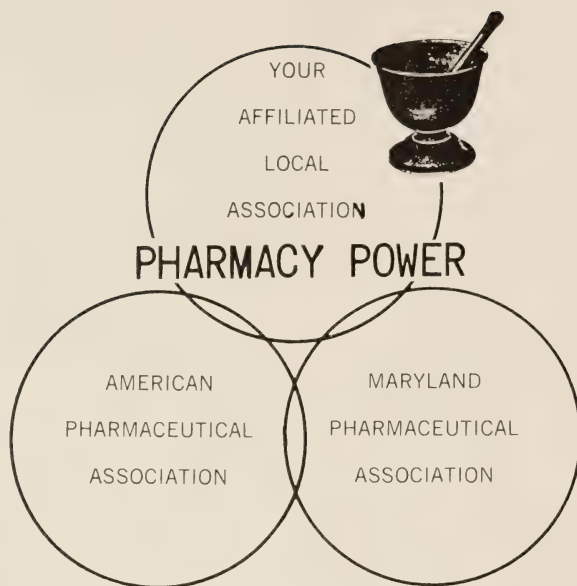
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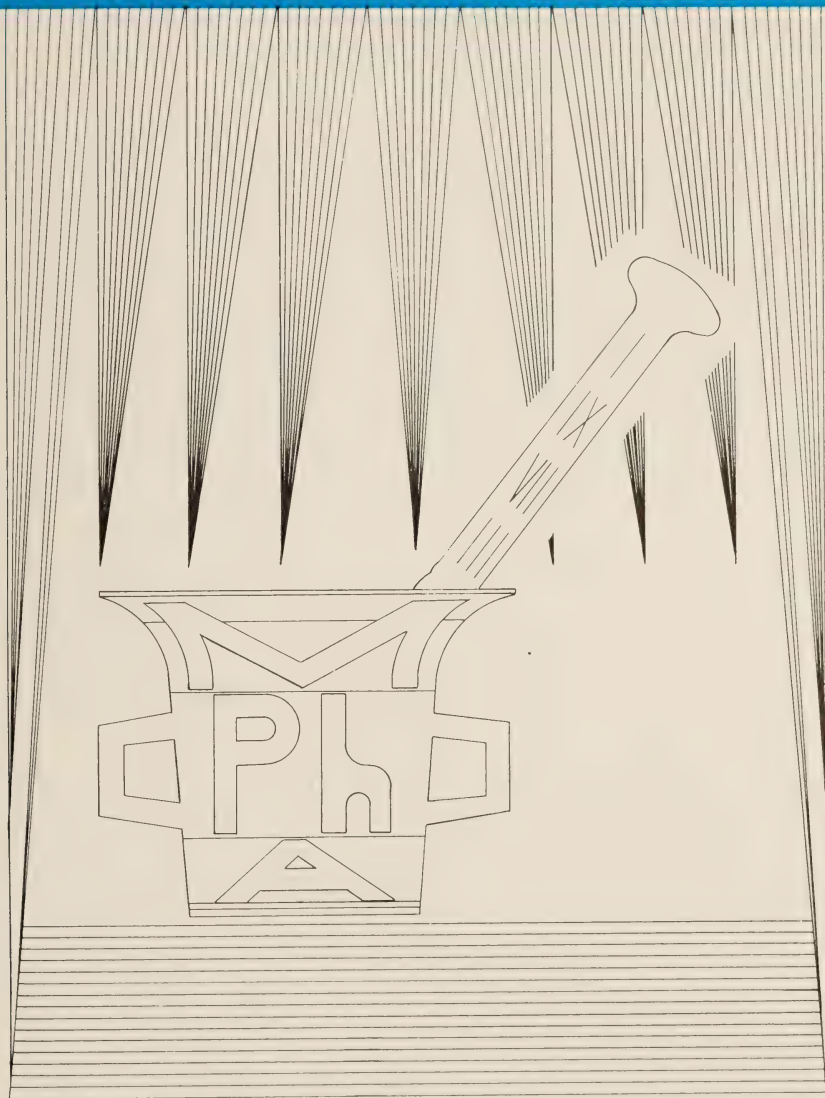
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the maryland pharmacist

JUNE
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Volume 49
Number 6



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Editorial . . .

PSF After Its First Year —

A Record of Progress

A little more than a year after its formal launching, the Pharmaceutical Services Foundation of Maryland, (PSF), has announced the receipt of a contract to administer a third-party payment prescription program for eligible employees of Sinai Hospital in Baltimore.

PSF, through the perseverance and dedicated efforts of its officers, board and committees developed a proposal which was accepted over those of several large national firms that have been in operation for many years.

This is an historic accomplishment for Maryland pharmacy for it is a recognition of confidence in the profession's ability to organize and administer an agency to serve the public through a third-party payment system.

Surely the decision to select PSF over well established firms was based on the high professional standing of its Board of Trustees, upon its standards of pharmaceutical practice, upon its machinery for drug utilization review and upon its broad base of support among pharmacists throughout the state.

With the support and cooperation of pharmacists, PSF should certainly be able to demonstrate that the Foundation can administer a third party program effectively and economically.

Most important however, will be the contribution of PSF to improvement of health care. This initial contract can be an opportunity to demonstrate that a pharmacy sponsored program affords greater assurance of availability and accessibility to high quality pharmaceutical service.

Some of the areas that merit attention are peer review and drug utilization review. From the standpoint of the vendor of service the matters of simplified administration, fair and equitable policies and prompt reimbursement are essential.

Maryland Pharmaceutical Association commends the PSF Board of Trustees for consummating their first contract. MPhA wishes PSF a successful operation for the benefit of better patient care, for the fulfillment of the needs of the management offering the plan and for advancing the professional interests of pharmacy.

—Nathan I. Gruz

A New Use For Patient Profile Cards

by Samuel Morris

There have been many reports in the literature concerning the patient who fails to maintain his drug therapy according to his physician's instructions. The average patient will miss doses or discontinue his medication even though this might be detrimental to his health. This has been attributed to the patient not being sufficiently impressed with the importance of taking his medicine, to the patient starting to feel better, to the patient being economically embarrassed, or to the patient believing his medicine is not doing anything to improve his health.

The product information accompanying Endo Laboratories' crystalline sodium warfarin states that patients being prescribed Coumadin (warfarin) are undergoing critical therapy. "Most physicians initiate anticoagulant therapy because they consider the patient a risk for serious thromboembolic complications. Once the dosage level is established you can expect the prescription to be renewed at quite regular intervals. Should the interval vary significantly, you might suspect that unless the regimen itself has been changed the patient is not adhering to it. It may be advisable to contact the patient's physician."

Thus, by using a renewal chart showing when patients should be refilling their prescriptions, there is a chance to prove again the value of the pharmacist to the health team and to the patient. The calendar should, of course, be part of a patient drug profile system and should be checked whenever a prescription is renewed for a drug indicated for long term maintenance therapy.

PHARMACY CALENDAR

October 14-19—National Association of Retail Druggists Annual Meeting, Portland, Oregon.

November 4-6—International Federation of Catholic Pharmacists 12th Congress, Mexico City, Mexico.

November 8-11—American Society of Consultant Pharmacists Annual Meeting, San Francisco, California.

December 9-13—American Society of Hospital Pharmacists Midyear Clinical Meeting, New Orleans, Louisiana.

1974

February 18-24—Maryland Pharmaceutical Association "Holiday in Israel" with optional extension tour to Rome.

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MPhA In Action

Board of Trustees Meetings

NATHAN I. GRUZ, *Executive Director*

May 3, 1973

The following is a summary of the actions taken at the May 3, 1973 meeting of the Board of Trustees:

- Noted copy of letter from National Pharmacy Insurance Council to National Association of Retail Drug-gists regarding NARD's decision to postpone joining NPIC.
- Noted acknowledgement from Dean Kinnard for MPhA contribution to Student Committee on Drug Abuse.
- Approved President's report noting dissatisfaction of attendance by delegates at Regional Meeting. The program content was declared excellent. The president commented on the Spain Convention Trip and the article in the *Sun* on the Drug Product Selection Law.
- Reviewed and accepted Treasurer's report.
- The Executive Director reviewed his activities which included various third party payment programs such as the Local 355 Drug Program and liaison with the Pharmaceutical Services Foundation and the Sinai Prescription Plan, U. S. P. Convention Special meeting, NARD Legislative and Public Affairs Conference, HEW Interagency Committee on Third Party Programs meeting on Pharmacist/Nursing Home Relations. Attended Board of Pharmacy meeting. The Secretary of Health has requested the Board to look into nursing home pharmacy ownership and pharmaceutical services. Also received information regarding the Maryland Food Committee program on distribution of baby foods. The Director noted the fine letter in the *Sun* of April 20th on patient records and prescription bargains by Trustee Melvin Rubin.
- Approved Membership Committee report.
- Received Professional Relations Committee report which noted outstanding exhibit on Drug Product Selection sponsored by MPhA at the annual meeting of the State Medical Society. Plans are completed on the workshop on Pharmacist's Role in Family Planning.
- Reviewed Board of Pharmacy activities. Decided to seek inclusion of state association representatives in meetings of District II of Boards and Colleges of Pharmacies.
- Discussed Drug Product Selection Law. MPhA flier was sent to members. Publicity was received in newspapers and television with MPhA comment. Consensus was to seek repeal of prescriber notification requirement.
- Noted that Peer Review Committee has drafted guidelines and is ready to work with Medicaid.

—Approved Prescription Insurance Plans Committee report along with policies presented by chairman Rubin. The definition of wholesale cost is to remain at *Blue Book* cost.

—Approved appointment to APhA House of Delegates of the President, President Elect and Executive Director. Two remaining delegates will be appointed by the officers.

New Members

The following new members were approved at the May 3, 1973 meeting of the Board of Trustees of the Maryland Pharmaceutical Association:

John Kenny, Jr., Read Drug and Chemical Co.
Arnold Spalter, Revco Drug Company

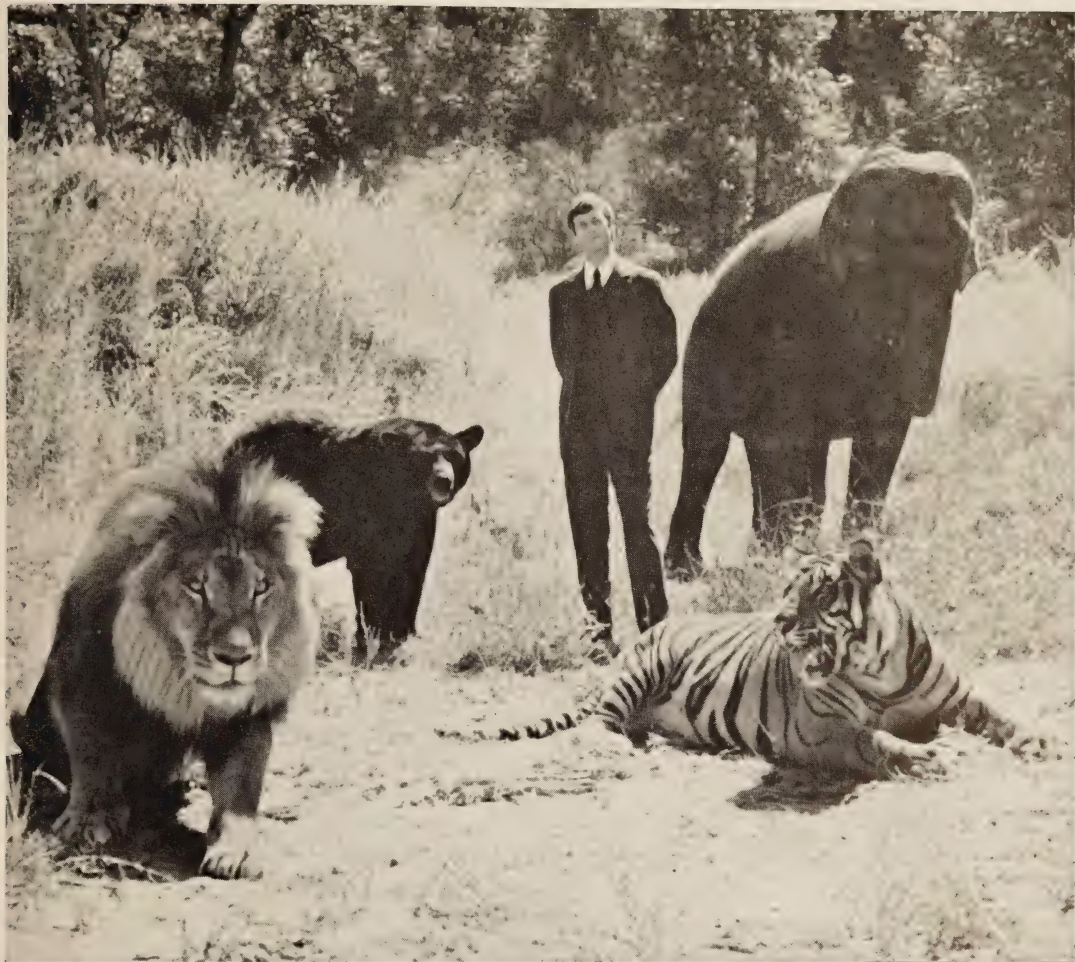
"Drug Product Selection Law" Order Forms Available

Forms which may be used to inform prescribers of a drug product selection under H.B. 573 (effective Dec. 1, 1972) may be ordered at the following rates (mailed third class): \$1.50 per hundred or \$14.00 per thousand. Check must accompany order. Mail to: Maryland Pharmaceutical Association, 650 W. Lombard Street, Baltimore, Maryland 21201.



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Restores what the body cannot store—the water-soluble vitamins.



Maryland Pharmaceutical Association House of Delegates Meeting

April 26, 1973

Friendship International Hotel

The House of Delegates of the Maryland Pharmaceutical Association was called to order by the Speaker, Henry G. Seidman, at 9:45 A.M. The Secretary, Nathan I. Gruz, called the roll, which indicated 31 delegates present. The minutes of the previous meeting on October 19, 1972 were approved.

The Speaker announced the appointment of Past President I. Earl Kerpelman as Parliamentarian. The Speaker addressed the House. Reports by President Bernard B. Lachman and the Board of Trustees Chairman Nathan Schwartz were made.

Legislative Committee Chairman Paul Freiman reviewed the highlights of the legislative session and expressed his thanks for the efforts of his committee and officers.

Melvin Rubin, Chairman Prescription Insurance Program Committee, stated he had worked on a list which would collate the provisions of the various third-party programs in Maryland. The results will be distributed to the membership. Mr. Rubin urged that a program be set up for membership to check with the Association office prior to signing up for new prescription programs.

Executive Director Gruz presented a report of his activities. He asserted the major issues are: third-party programs, maintenance of patient medication records (profiles), drug product selection (generic prescribing), continuing education and prescription price posting. He noted the attendance of Leonard DeMino, new director of Professional Relations for Peoples Drug Stores.

Ronald Lubman, a member of the Mayor's Committee on Small Business (Baltimore City) reported on a Crime Seminar to be held on May 1st.

Stephen Hospodavis, Chairman MPhA Professional Relations Committee, reviewed the observance of Poison Prevention Week, the MPhA Scientific Exhibit on Drug Product Selection at the State Medical Society Annual Meeting and a workshop on the Pharmacists Role in Family Planning on June 7th.

There was then a discussion of the implementation of H.B. 573 (1972) on Drug Product Selection.

S. Ben Friedman read the following amendment for the Constitution and By Laws Committee: To amend Section 1. of Article IV of the Constitution to read 14 members in place of 13 for the Board of Trustees and to add the *Vice Speaker* to the Board.

I. Earl Kerpelman, Chairman of the Nominating Committee, read his report which was accepted and referred to New Business.

New Business

1. Report of Constitution and By Laws Committee. Adopted on motion of G. Freedenberg/R. Lubman.
2. S. Ben Friedman suggested that consideration be given for a term of more than one year for Speaker of the House. Referred to Constitution and By Laws Committee.
3. Paul Freiman moved that MPhA voice its displeasure with the NARD for endorsement of the PMA position on repeal of "antisubstitution" laws. Seconded by Lubman and passed.
4. Other issues were: Commendation of Roche and Searle for their fair return goods policies, activation of a Consumer Affairs Committee and regulation of third-party programs for the State Insurance Commissioner.
5. Nominating Committee Report—I. Earl Kerpelman, Chairman.

President Elect—PAUL FREIMAN

Vice President—HENRY G. SEIDMAN

DOMINIC VICINO

Treasurer—MORRIS LINDENBAUM

Trustees: for term of Philip Lindeman:

SAMUEL MORRIS

JAMES TRUITT

for term of John McHugh:

EDWARD NUSSBAUM

RICHARD D. PARKER

On motion of Kerpelman/Lindeman, the slate was adopted unanimously for mail ballot by the general membership.

6. Student delegate George Grimes spoke of OTC drug TV advertising, counseling on OTC's by pharmacists and opportunities for the graduating class.
7. President Lachman, on behalf of MPhA, commended Norman J. Levin, outgoing President of the Maryland Board of Pharmacy for his dedicated efforts during his three terms totaling 15 years.

The House recessed at 1:15 P.M.

Following lunch and an address by Delegate Steven V. Sklar (Baltimore City, 5th District) on pharmacy and drug legislation, the House reconvened at 2:30 p.m.

A proposal for support of legislation for tighter gun controls was not endorsed.

The use of Educational TV for transmitting information on pharmacy to the public was urged.

Student Delegate Peggy Yules spoke of the need for information on the effect of Maryland legislation on reciprocity, on MPhA services to students and the School of Pharmacy and the employment service of the MPhA.

The House of Delegates adjourned at 2:45 p.m. to be followed by the Workshop on Patient Medication Records concluding the Spring Regional Meeting.



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- Hospital pharmacy work flow analyses and modernization ■ Promotional sundries buying services ■ Computer management control and customer charge accounts services

Maryland Board of Pharmacy News

Pharmacy Changes

The following are the pharmacy changes for the month of May:

New Pharmacies

Evans Distributors & Jewelers, Inc., Stephen H. Baumgarten, President; 5060 Nicholson Lane, Rockville, Maryland 20852.

No Longer Operating As Pharmacies

Seton Psychiatric Institute-Pharmacy, Sister Anne William Rickle, President; 6400 Wabash Avenue, Baltimore, Maryland 21215.

Hunting Ridge Pharmacy, David Lebson and Hyman Lebson, 4605 Edmondson Avenue, Baltimore, Maryland 21229.

Changes of Ownership, Address

Bailey's Pharmacy, Stanley B. McCabe, President (Change of ownership); 714 Philadelphia Avenue, Ocean City, Maryland 21842.

Postcoital Diethylstilbestrol

In agreement with its extragovernmental physician-advisers, the Food and Drug Administration has approved, under restricted conditions, postcoital (contraceptive) use of diethylstilbestrol (DES), a synthetic estrogen. Adequate evidence to support the use of any other estrogen for this purpose is not presently available.

The Agency considers the use of DES for this purpose to be safe only as an emergency measure (in situations such as rape, incest, or where, in the physician's judgment, the patient's physical or mental well-being is in jeopardy) and explicitly warns against its routine or frequent use as a contraceptive.

Physicians are urged, prior to prescribing DES for this purpose, to inform patients (or guardians) fully of the possible side effects of the drug, and of alternative measures available and their hazards, so that the patient may participate in an informed way in the decision to use the drug. Pregnancy should be ruled out by appropriate tests prior to instituting therapy, so that no unnecessary exposure of a fetus to DES occurs.

The efficacy of DES in preventing pregnancy depends upon the time-lapse after coitus and dosage of the drug. The currently recommended dosage is 25 mg twice a day for 5 continuous days beginning, preferably, within 24 hours and not later than 72 hours after exposure. When this dosage is given within the specified time interval after sexual intercourse, DES is highly effective in

preventing conception. But the patient must be warned to take the full course of the drug in spite of the nausea which commonly occurs, if it is to be effective.

There is at present no positive evidence that the restricted postcoital use of DES carries a significant carcinogenic risk either to the mother or fetus. However, because existing data support the possibility of delayed appearance of carcinoma in females whose mothers have been given DES later in pregnancy, and because teratogenic and other adverse effects on the fetus with the very early administration recommended are ill understood, failure of postcoital treatment with DES deserves serious consideration of voluntary termination of pregnancy.

Requirements For Protection Against X-rays

From 1300 to 6000 cancer deaths annually are caused by exposure of the American public to present levels of diagnostic X-rays. In addition, ill health results from genetic damage caused by the exposure. These conclusions were reached by the National Academy of Sciences/National Research Council through its study on *The Effects on Populations of Exposure to Low Levels of Ionizing Radiation*. A report on the study was recently released.

Improved X-ray Technique Needed—The NAS-NRC study further shows that present exposure of the population to X-rays, and the associated toll in lives, can be significantly reduced through simple improvements in X-ray techniques. For example, present genetic damage from X-rays can be reduced by up to 50 percent through improved techniques such as using gonad shielding, particularly on male patients and restricting the size of the X-ray beam to the area of clinical interest. This is especially important during those X-ray procedures in which the reproductive organs are in the direct X-ray beam, as during examinations of the lower back, lower abdomen, and hip. In view of the known leukemogenic effect of X-rays, avoiding needless exposure of the bone marrow is also of special significance. Because of the increased radiosensitivity of embryonic tissue, special prudence should be exercised in prescribing X-ray examinations for pregnant or potentially pregnant women.

Existing X-ray Equipment Need Not Be Upgraded—FDA has asked State radiation control agencies to advise diagnostic X-ray equipment dealers and users that the new Federal radiation protection standard for X-ray machines and components does not require modification of equipment now being used.

Geigy

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MAC 28-50-10

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History of The Baltimore Veteran Druggists' Association

by

B. F. ALLEN, Ph.D.

Associate Professor of Pharmacy, University of
Maryland, School of Pharmacy

A continuing article, Part I was published in the December, 1972 issue of this journal. The author serves as Secretary-Treasurer of the Baltimore Veteran Druggists' Association.

The members of the Association have always constituted a remarkable roster of prominent Baltimore pharmacists and those interested in pharmacy. The high calibre of the membership is shown by the background and interests of the charter members.

B.V.D.A. members have been very active in national and local pharmaceutical drug organizations; the alumni groups of the old Maryland College of Pharmacy, the University of Maryland, and the School of Pharmacy; as well as politics (one was elected to the Baltimore City Council and later to the State House of Delegates, another was Liquor Commissioner of Baltimore, a third member was not only a City Councilman, but also a Magistrate and member of the Zoning Board).

Noteworthy of recording is that members of the local veterans group were presidents of the following organizations: *American Pharmaceutical Association*—Eberle (1910), Dohme (1916), Dunning (1929), Swain (1933), and DuMez (1939); *Maryland Pharmaceutical Association*—Dohme (1899), W. E. Brown (1903), Fouch (1908), Thomas (1909), Morgan (1910), Hancock (1911), Frames (1913), Bunting (1915), Hodson (1917), Millard (1919), Williamson (1921), Meyer (1923), Harris (1925), Dunning (1926), H. W. Allen (1928), Kantner (1932), Ludwig (1934), Strasburger (1936), Swain (1937), Hewing (1939), Black (1943), Harrison (1945), Austin (1947), Diener (1949), Waples (1951), Muehlhause (1953), Davidov (1955), Frank Block (1958), Weiner (1964); *Travelers' Auxiliary Maryland Pharmaceutical Association*—Neal (1919), Hendler (1920-21), Armstrong (1927), Love (1932), Keppler (1933), L. B. Wright (1935), Leatherman (1936), Weyprecht (1944), Vogel (1946), Crozier (1948), Dawson (1949), Hugg (1954); *Alumni Association School of Pharmacy*—Lowry (1926), Harrison (1930), Rettaliata (1932), Black (1933), Hewing (1934), Davidov (1935), Wannenwetsch (1936), Strevig (1937), Austin (1939), Muehlhause (1941), R. H. Wagner (1945), Andrews (1946), Joseph Cohen (1948), Frank Block (1950), Balassone (1951), Raichlen (1952), Warfield (1957), I. I. Cohen (1960), Friedman (1963), Libowitz (1966), Ichniowski (1967), Gruz (1968); and the following served as *Honorary Presidents*: Morgan (1931), Wich (1932), Fouch (1935), Harris (1940),

Sonnenburg (1941), Hodson (1943), Stevens (1945), Dunning (1948), Sencindiver (1949), Bunting (1950), Cole (1953), Black (1954), Wannenwetsch (1955), Austin (1957), Lowry (1958), Helm (1959), Strasburger (1963), Davidov (1965), Frank Block (1967), Spigelmire (1969), Wooten (1970), Cooper (1971), Slama (1973); *Baltimore Retail Druggists' Association**—Thomas (1909-10), Williamson (1912-28), Harris (1929-32), Wannenwetsch (1935), Kronthal (1936), Waples (1940), Austin (1941), Harrison (1942), Muehlhause (1943), Settler (1946), Cooper (1948), Davidov (1949), Frank Block (1953).

There has always been a wealth of experience contained in the membership of the Baltimore Veteran Druggists' Association and pharmacy is indeed fortunate in having such an organization where the past, present and future is blended together. The group co-operated in the centennial celebration of the Pharmacy School in 1941. The following served as Chairmen of the different committees: Muehlhause, General Chairman; Andrews, Reception and Dance; Cole, Program; Davidov, Publicity; DuMez, Session on Education; Dunning, Finance; Harrison, Banquet; Helm, Registration; Strevig, Reservations.

Also, the following veterans have been recipients of the *Honored Alumnus Award* given by the Alumni Association School of Pharmacy: Dunning (1949), Swain (1950), Bunting (1951), Cole (1953), Black (1955), Wannenwetsch (1956), Kantner (1959), Joseph Cohen (1961), Foss (1962), Slama (1963), Balassone (1965), Warfield (1968), Frank Block (1970).

In 1949, Frank L. Black was elected the first President of the newly formed University of Maryland Alumni Club of Baltimore and in 1959 Frank Block served as President of this same group.

The following charter members of this association graduated from the old Maryland College of Pharmacy located on Aisquith Street, two doors north of Fayette Street: H. W. Allen (1895), Bond (1886), Bunting (1899), Dorman (1894), Dunning (1897), Fouch (1886), Frames (1882), Harris (1890), Kelly (1902), Meyer (1892), Millard (1891), Morgan (1891), Neal (1899), Thomas (1872).

A number of the founding fathers were also officers, at one time, in the Alumni Association of the Old Maryland College of Pharmacy. Charles C. Neal was Record-

*The name was changed in 1958 to the Baltimore Metropolitan Pharmaceutical Association.

ing Secretary in 1899, J. Emory Bond, President in 1903, John B. Thomas, First Vice-President in 1903, and E. F. Kelly, Secretary in 1904.

In addition to practicing community pharmacists, the membership has included a President of the University of Maryland (H. C. Byrd); a Chairman of the Board, Emerson Drug Company (Joseph F. Hindes); the General Manager of the Pharmaceutical Laboratories, Sharp & Dohme (Charles C. Neal, who also donated flowers for Alumni banquets from 1926 until his death in 1938); the President of the Baltimore Drug Exchange in 1957 (William C. McKenna); a pharmacist-in-chief to the Johns Hopkins Hospital (R. S. Fuqua who had many years of experience in hospital practice and was interested in all matters pertaining to professional and ethical pharmacy); and John C. Bauer, recipient of the first Doctor of Philosophy degree from the School of Pharmacy, University of Maryland and who in 1935 presented a paper entitled "The Possibility of Clinical Service As a Phase Of Pharmaceutical Practice."

Membership of the Baltimore Veteran Druggists' Association: (1926-1973)

Allen, Benjamin F.*	Cole, B. Olive
Allen, Howell W.**	(Honorary)
Andrews, Marvin J.*	Cooper, Morris L.*
Armstrong, Charles L.	Crozier, John A.*
Asbill, John L.	Davidov, Hyman*
Austin, Charles S.	Dawson, Luther B.
Baer, Philip C.	Diener, Nelson G.
Balassone, Francis S.	Dohme, A. R. L.**
(Honorary)	Donnet, John*
Bauer, John C.	Dorman, J. William**
Berman, Frederick T.	Downs, Edward R.**
Bindok, Edward J.*	DuMez, A. G.**
Binstock, Albert*	Dunning, H. A. B.**
Black, Frank L.	Eberle, Eugene G.**
Blaney, Charles M.	Fedder, Eli
Block, Frank*	Foss, Noel E.*
Block, Samuel G.*	Fouch, William M.**
Bodeman, William	Frames, J. Fuller**
(Honorary)	Friedman, Milton A.*
Bond, J. Emory**	Fuqua, R. S.
Boucsein, William G.	Gaboff, Benjamin
Bray, William M.	Gaver, Paul G.*
Brown, William E.	Glaser, Louis*
Brown, Leroy P.	Gordon, Jack B.
Bunting, George A.**	Grau, George P.
Burbage, Landon W.*	Gruz, Nathan I.*
Byrd, H. C.	Hancock, James E.
(Honorary)	Harris, Samuel Y.**
Caplan, Carl C.*	Harrison, Harry S.
Carmel, Joseph*	Heck, Andrew
Cohen, Joseph	Helm, Emory G.
Cohen, Irving*	Heusler, Philip
Cohen, Samuel C.*	Hewing, Alvin N.

Hindes, Joseph F.	Raichlen, Samuel I.*
Hodson, Eugene W.	Retaliata, Leo C.*
Hugg, Joseph J.*	Roddick, Wilken M.
Ichniowski, Casimir T.*	Rodowskas, Christopher A.*
Jamieson, Joseph D.	Rosenberg, Max S.
Jeppi, Samuel P.*	Rosenfeld, Albert*
Johnson, W. L.	Sabatino, Louis T.*
Kahn, Moses S.	Schmidt, Charles J.*
Kammer, William H.	Sencindiver, Judson H.
Kantner, Leahmer M.*	Settler, M. Martin*
Kelly, Evander F.**	Shoemaker, William C.*
Keppler, Milton J.*	Slama, Frank J.*
Kinnard, William J. Jr.	Snyder, Paul J.
(Honorary)	Sonnenburg, Charles E.
Klingel, James A.	Spigelmire, Charles E.*
Kraus, Fred	Stagmer, Owen R.
Kronthal, Jacob L.*	Stevens, Charles
Lacourse, Anthony	Strasburger, Melville
Lamkin, Howard C.	Strevig, John A.
Lauer, William G.	Swain, Robert L.**
Leatherman, A. G.*	Thomas, John B.**
Levin, Bernard*	Ulman, Bernard
Lewis, F. Harold*	Ulman, Ferdinand L.
Libowitz, Aaron M.	Vogel, Walter W.
Love, Kenneth F.	Wagner, Manuel B.
Lowry, William J.	Wagner, Raphael H.*
Ludwig, Andrew F.	Wannenwetsch, John F.
Mayer, Alexander M.*	Waples, William E.
McComas, J. Ross*	Warfield, H. Nelson*
McGinnity, John J.	Wargell, Walter F.
McKenna, William C.	Warren, Daniel A.
Meyer, Charles L.**	Waterman, Richard H.*
Millard, David R.**	Weiner, Solomon
Moon, Dudley C.	Weyprecht, George C.
Morgan, Charles**	Wich, Conrad L.
Muehlhause, Otto W.	Wieland, John
Mundorf, H. K.	Williamson, R. E. Lee**
Muth, Edward S.	Wolfe, G. Ernest
Neal, Charles C.**	Woodford, Benjamin W.
Ohlendorf, Albert W.*	Wooton, Robert O.*
Oldham, Leroy	Wright, Francis G.
Parelhoff, Maurice*	Wright, Lealon B. Jr.
Pfeifer, C. Edward*	Wright, Thomas G.
Pierce, Walter L.	Yingling, Raymond B.
Pierpont, Mervin G.	Zepp, William S.
Purdum, Frank C.	Hendler, L. Manuel
Purdum, W. Arthur	

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Hospital Pharmacy Section

Eighth Annual Hospital Pharmacy Seminar "Clinical Pharmacy – Pharmacy of the Future?"

The Diplomat Hotel in Ocean City, Maryland was the site of the Eighth Annual Hospital Pharmacy Seminar of the Maryland Society of Hospital Pharmacists. The three-day affair, held June 15, 16, and 17, 1973, was attended by more than 100 registrants and emphasized "Clinical Pharmacy" as its main theme.

The Saturday morning session featured a panel discussion on "Clinical Pharmacy Services in Three Maryland Hospitals" and was moderated by Dr. John A. Gans, Coordinator of Clinical Instruction at the Philadelphia College of Pharmacy. Other panelists for this session were: Dr. Robert A. Kerr, Acting Assistant Director for Clinical Pharmacy Services at the University of Maryland School of Pharmacy; Dr. Thomas S. Sisca, Director of Clinical Pharmacy Services at the Easton Memorial Hospital; and Patrick H. Birmingham, Director of Pharmacy and Medical Supply Service at the Good Samaritan Hospital in Baltimore.

At the afternoon session, Thomas J. Garrison, Director of Pharmacy at Lakeside Hospital in Kansas City, Missouri, spoke on "Clinical Pharmacy Services in Small Hospitals." The second afternoon speaker, Clifford E. Hynniman, spoke on "Clinical Pharmacy and the Hospital Drug Distribution System." Dr. Hynniman is Director of Pharmacy at the Nortons Children's Hospitals in Lexington, Kentucky.

At Sunday morning's session, a talk entitled "Model Institutional Pharmacy Law in Maryland" was presented by Carl T. DeMarco, J.D., General Counsel for the American Society of Hospital Pharmacists. Afterwards, Herbert L. Flack, Director of Pharmacy Services at the Hospital of the University of Pennsylvania, spoke on "Clinical Pharmacy Services in the Ambulatory Area."

The Saturday evening Installation Banquet saw Thomas E. Patrick, incoming President, take over the gavel from outgoing President Normand A. Pelissier. Mr. Pelissier was presented the Geigy Achievement Award by Geigy representative Richard Plotkin. The W. Arthur Purdum Award was presented to Dr. Peter P. Lamy by Mary W. Connelly, Chairman of the W. Arthur Purdum Award Selection Committee. Also receiving an award was Mrs. Linda Bosco, University of Maryland School of Pharmacy, Class of 1973. Mrs. Bosco received the MSHP Student Achievement Award.

Robert H. Henry, Director of Professional Affairs, United States Pharmacopeia, delivered the banquet address and lived up to his reputation of being the most entertaining speaker in pharmacy. Arthur N. Riley served as General Chairman of the 1973 Seminar with Robert E. Snyder serving as Program Chairman.

May Meeting

The May meeting of the Maryland Society of Hospital Pharmacists was held at St. Joseph's Hospital. A buffet dinner co-sponsored by Eli Lilly and Parke-Davis Co. preceded the meeting. Guest speaker at the meeting was Dr. David A. Blake, Associate Professor and Chairman, Department of Pharmacology and Toxicology, University of Maryland, School of Pharmacy. Dr. Blake discussed current and future treatment of opioid addiction. A short business session followed during which election results were announced.

The newly elected officers for the 1973-1974 term are as follows:

President Elect.....	Vincent dePaul Burkhardt
Secretary	Thomas Walker
Treasurer	Harry Hamet
Board of Directors	Clarence Fortner

Other 1973-1974 officers are Thomas E. Patrick, President; Normand A. Pelissier, Chairman of the Board of Directors; and Samuel Lichter and Patrick H. Birmingham, members of the Board of Directors.

The following delegates were elected to represent the Society at the Annual Meeting of the ASHP in Boston: Robert E. Snyder, Clarence L. Fortner, and Normand A. Pelissier.

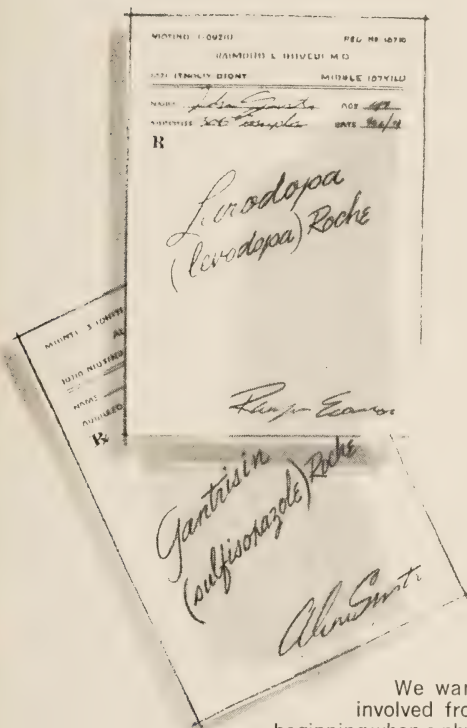
Clarence L. Fortner Receives Military Section Literary Award

Clarence L. Fortner, Chief, Patient Care Pharmacy Service, USPHS Hospital, Baltimore, Maryland, has been chosen as the ninth recipient of the American Pharmaceutical Association Military Section Literary Award.

Mr. Fortner's article: THE ACUTE LEUKEMIAS, published in the *Journal of the American Pharmaceutical Association*, Vol. NS12, No. 9, September, 1972, was judged to have been the best original contribution by a member of the Military Section to the pharmaceutical literature during the period July, 1971 through December, 1972.

The Award was presented to Mr. Fortner at the Military Section Luncheon, Monday, July 23, during the APhA Annual Meeting in Boston. The Award is sponsored by Eli Lilly and Company and consists of a \$500 honorarium and a plaque. Members of the Section's Selection Committee were William H. Hotelling, III, Potomac, Maryland; Robert A. Kerr, Baltimore, Maryland; and Irwin Title, Falls Church, Virginia.

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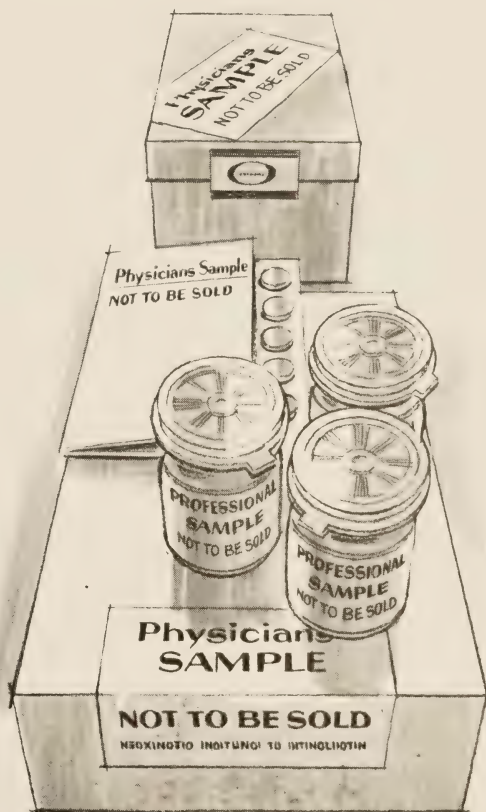
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Larodopa offers consistently high quality—and only Larodopa provides the Roche-patented tablet form of levodopa. The scored, easily divided tablet makes it possible to use a single-strength tablet to vary

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Consistent with pharmacy-oriented policies, Roche maintains equitable and competitive pricing, assures a liberal "returned goods" credit and does not distribute unsolicited samples of Larodopa (levodopa).





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Before prescribing, please consult complete product information, a summary of which follows:

In order to reduce the high incidence of adverse reactions, it is necessary to individualize the therapy and to gradually increase the dosage to the desired therapeutic level.

Indications: For the treatment of idiopathic Parkinson's disease (paralysis agitans), postencephalitic parkinsonism, manganese intoxication, symptomatic parkinsonism due to carbon monoxide intoxication, and parkinsonism in the elderly associated with cerebral arteriosclerosis.

Contraindications: In patients receiving MAO inhibitors (the latter must be discontinued two weeks prior to initiating therapy with Larodopa); in narrow angle glaucoma; and in patients with known hypersensitivity to levodopa.

Warnings: Administer cautiously to patients with severe cardiovascular or pulmonary disease, bronchial asthma, renal, hepatic or endocrine disease. Administer with care and in a facility with a coronary care unit or intensive care unit to patients with myocardial infarction who have residual atrial, nodal or ventricular arrhythmias. Be alert to possibility of upper gastrointestinal hemorrhage in patients with a history of active peptic ulcer disease. Monitor carefully all patients for development of depression with concomitant suicidal tendencies. Treat psychotic patients with caution.

Oral doses of 10 to 25 mg of pyridoxine hydrochloride (vitamin B₆) rapidly reverse the toxic and therapeutic effects of Larodopa (levodopa). Therefore, carefully consider concomitant administration of the two agents. In pregnancy, weigh potential benefits against possible hazards. Do not use in nursing mothers. Safety of Larodopa in children under age 12 not established.

Precautions: Periodic evaluations of hepatic, hematopoietic, cardiovascular and renal function recommended during extended therapy in all patients. Patients with chronic wide angle glaucoma may be treated cautiously provided intraocular pressure is well controlled and monitored carefully during therapy. To patients on an antihypertensive drug, administer carefully, adjusting dosage if necessary. For patients receiving pargyline, see note on MAO inhibitors contraindications.

Adverse Reactions: *Most serious*—occurring most frequently: adventitious movements (e.g., choreiform and/or dystonic); *most serious*—occurring less frequently: cardiac irregularities and/or palpitations, orthostatic hypotensive episodes, brady-

kinetic episodes (the "on-off" phenomena), mental changes including paranoid ideation and psychotic episodes, depression with or without the development of suicidal tendencies, dementia, and urinary retention; *most serious*—occurring rarely: gastrointestinal bleeding, development of duodenal ulcer, hypertension, phlebitis, hemolytic anemia, agranulocytosis, and convulsions. (The causal relationship between convulsions and Larodopa has not been established.)

Less serious—occurring relatively frequently: anorexia, nausea and vomiting with or without abdominal pain and distress, dry mouth, dysphagia, sialorrhea, ataxia, increased hand tremor, headache, dizziness, numbness, weakness and faintness, bruxism, confusion, insomnia, nightmares, hallucinations and delusions, agitation and anxiety, malaise, fatigue and euphoria; *less serious*—occurring less frequently: muscle twitching and blepharospasm (which may be taken as an early sign of overdosage; consideration of dosage reduction may be made at this time), trismus, burning sensation of the tongue, bitter taste, diarrhea, constipation, flatulence, flushing, skin rash, increased sweating, bizarre breathing patterns, urinary incontinence, diplopia, blurred vision, dilated pupils, hot flashes, weight gain or loss, dark sweat and/or urine; *less serious*—occurring rarely: oculogyric crises, sense of stimulation, hiccups, development of edema, loss of hair, hoarseness, priapism and activation of latent Horner's syndrome.

The following have been noted: elevations of BUN, SGOT, SGPT, LDH, bilirubin, alkaline phosphatase or PBI; occasionally, reductions in WBC, hemoglobin and hematocrit; elevations of uric acid with use of colorimetric method but not with uricase; occasionally, positive Coombs test; leukopenia, requiring at least temporary discontinuance of Larodopa (levodopa).

Dosage and Administration: Because of the necessity for individualizing therapy, the usual optimal therapeutic dosage should not exceed 8 Gm, and should be carefully titrated for each individual patient. The physician should thoroughly familiarize himself with the information in the package insert before instituting therapy.

How Supplied: *Tablets*, pink, scored, containing 0.1 Gm levodopa (imprinted ROCHE 72), bottles of 100; containing 0.25 Gm levodopa (imprinted ROCHE 57) or 0.5 Gm levodopa (imprinted ROCHE 56)—bottles of 100 and 500.

Capsules, containing 0.25 Gm levodopa (pink and beige, imprinted ROCHE 55) or 0.5 Gm levodopa (pink, imprinted ROCHE 54)—bottles of 100 and 500.



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University of Maryland School of Pharmacy Alumni Association



—Photos by Paramount Photo Service

Top left: Graduates of the Class of 1923 who received 50 year certificates are (l to r) Walter E. Albrecht, Nathan Hecker, Benjamin Ralph Katz, Morris Rockman (front), Dr. Theodore E. Stacy, Raphael W. Wagner and Dr. Bernard Cohen. Top right: Incoming President Charles A. Sandler (l) receives gavel from outgoing President Ronald A. Sanford.

Lower left: Victor H. Morgenroth, Jr., (r) is presented the Honored Alumnus Award by his business partner Joseph U. Dorsch. Lower right: Dr. Frank J. Slama (l) is presented the Honorary President's gavel and plaque by Samuel Goldstein.

47th Annual Graduation Banquet

The School of Pharmacy Alumni Association of the University of Maryland held its 47th Annual Graduation Banquet at Eudowood Gardens, Baltimore, in honor of the 60 graduates of the class of 1973.

The invocation was given by Reverend Walter G. Malinsky, Pastor, Emmanuel Lutheran Church, Catonsville, Maryland. After the dinner, President Ronald A. Sanford made the opening remarks and introduced the guests. Greetings from the University of Maryland were conveyed by Dr. Albin O. Kuhn, Chancellor of the Baltimore Campus. The 1973 Honored Alumnus Award was presented to Victor H. Morgenroth, Jr. by Joseph U. Dorsch. Mr. Samuel Goldstein presented the 1973 Honorary President's Award to Dr. Frank J. Slama, Secretary Emeritus of the Alumni Association and former member of the faculty of the School of Pharmacy. President San-

ford then presented a check to Student APhA-MPhA President Walter J. Hryszko towards the work of the Student Committee on Drug Abuse Education.

Dean William J. Kinnard, Jr. introduced the members of the 1973 graduating class and the response was given by Class President Martin Herman. President Sanford then presented 50 year certificates to members of the class of 1923. The following received 50 year certificates: Walter E. Albrecht, Nathan Hecker, Benjamin Ralph Katz, Morris Rockman, Dr. Theodore E. Stacy, Raphael W. Wagner and Dr. Bernard Cohen. The response was given by Mr. Benjamin F. Katz, Class Historian, Class of 1923.

Charles Spigelmire, Installation Officer, installed the 1973-1974 officers. Newly installed President Charles A. Sandler presented the Past President's Award to Ronald A. Sanford. Reverend Malinsky then performed the Benediction.

Morgenroth Receives Honored Alumnus Award

Victor H. Morgenroth, Jr. was the recipient of the 1973 Honored Alumnus Award of the University of Maryland School of Pharmacy presented at the annual Graduation Banquet of the School of Pharmacy Alumni Association held on May 30.

Mr. Morgenroth is co-owner of two pharmaceutical centers operating as Voshell's Pharmacies. He received his B.S. in Pharmacy from the University of Maryland, School of Pharmacy in 1939. He was Vice President of the American Pharmaceutical Association in 1968-1969 and was on the National Formulary Admissions Committee from 1965-1969. He served as President of the Maryland Pharmaceutical Association, the Baltimore Metropolitan Pharmaceutical Association, and the Alumni Association of the University of Maryland School of Pharmacy. A member of the American College of Apothecaries, he served as President of the ACA in 1970. In 1968 he received the Bowl of Hygieia Award.

In addition, Mr. Morgenroth is a member of the Baltimore Mayor's Commission for the Aged, serves on the Maryland State Advisory Board of Hospital Licensure and acts as consultant for the Medical Care Division of the Baltimore City Health Department. He has been a member of Rho Chi since 1939 and is an Associate Member of the American Society of Hospital Pharmacists.

Prince Georges-Montgomery County Pharmaceutical Association



Prince George's-Montgomery County Pharmaceutical Association Installation Banquet, Golden Bull Inn, Adelphi, May 6, 1973 (l to r) Edward Nussbaum, Chairman of the Board; Paul Reznick, Secretary; Congressman Gilbert Gude (R., 7th), Banquet Speaker; and Douglas Llewellyn, Station WTOP, Master of Ceremonies.



Outpatient Education

While patients wait to have their prescriptions filled at the new North Wing of the University of Maryland Hospital, they can view a self-contained mini-theatre which gives educational slide-tape presentations. Currently, three such films are in use. These include one on smoking, another on asthma, and a third on family planning.

The films used range from 9 to 12 minutes in length and are among the 30 produced so far by Medfact, a private firm developing means to educate patients about illnesses, and health regimens.

TAMPA News

The April meeting of the Traveler's Auxiliary of the Maryland Pharmaceutical Association was held at the Brentwood Inn. The meeting was called to order by John Matheny who introduced the evening speaker, Bernie Ulman. Mr. Ulman spoke about the NFL and related various episodes concerning incidents that occurred during his time as referee in the NFL.

A motion was made and approved to contribute to the Maryland Pharmaceutical Foundation. Lloyd Burton was accepted into membership.

TAMPA Ladies Night was held at the Green Spring Inn on May 9 with approximately 84 people present.

Eastern Shore Pharmaceutical Society

The Eastern Shore Pharmaceutical Society held its spring meeting in Ocean City at the Ships Cafe Marina on June 3, 1973. A team of speakers from the University of Maryland School of Pharmacy spoke on Drug Abuse.

BNDD Inventory

For those firms that were in business and took inventory May 1, 1971, the 1973 inventory should have been taken May 1, 1973. For firms which began operation after that date, inventory was required as soon as they engaged in business. Flexibility is allowed: If the inventory was not taken on May 1, 1973, it may be taken on the registrant's regular general inventory date if it does not vary by more than six months from the biennial date, or any other fixed date which does not vary by more than six months from the biennial date. If an alternative is elected, the pharmacist must notify BNDD, Washington, D.C. 20537, of this election and of the date on which the biennial inventory will be taken.

Carcinogenic Fibers

Microscopic fibers of a certain size can cause cancer in laboratory rats, regardless of the chemical composition of the fibers, according to Dr. Mearl F. Stanton of the National Cancer Institute (NCI). The scientist believes that the cancer-causing activity of asbestos, for example,

is due to its fibrous structure. Dr. Stanton experimented with laboratory rats to test the ability of various fibrous and non-fibrous substances to cause cancer of the membrane surrounding the lungs. Results showed that very fine fibers of asbestos, glass, or sapphire caused a high incidence of pleural cancers in the animals, while coarse fibers or powdered material of the same compositions only rarely caused cancer. The cancer-causing fibers were between one-half and five microns in diameter and less than 80 microns long, that is, less than one-hundredth as thick as an eyelash and under one-tenth as long.

APhA, ASHP Establish Board-Level Joint Committee

The American Pharmaceutical Association and the American Society of Hospital Pharmacists have established, on a permanent basis, a board-level committee consisting of three officers of each organization to meet at least twice each year to discuss matters affecting the profession and the respective organizations. The new committee will also carry on discussions to explore inter-organizational relationships.

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*a matter of professional interest
to the pharmacist:*

there's a great deal being said about hypertension these days... and it's being taken to heart

As a pharmacist, you are well aware that the cardiovascular complications of hypertension can mean early death or crippling disease: congestive heart failure, renal failure, stroke, myocardial infarction.

The prescriptions that you fill for diuretics and other antihypertensive medications are, along with proper diet and weight control, the best preventive measures known against these complications. And the increased number of these prescriptions may have led you to wonder whether the actual incidence of hypertension has risen.

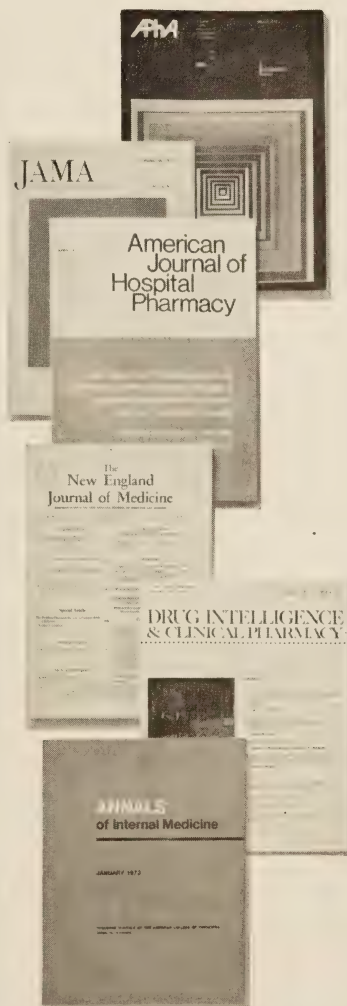
Perhaps it has. But not necessarily. Improved case-finding and physicians' decisions to institute drug treatment at an earlier stage of the disease could also be responsible.

At what reading does hypertension begin?

There are differing views as to where hypertension begins: some physicians say blood pressure readings of 140/90 mm Hg warrant further examination, while others use 160/95 mm Hg as the cutoff. But there is little doubt that a person's risk of developing the complications of hypertension is proportional to his blood pressure level.

Prompt detection and treatment urged

It can be expected that more people will become aware of their hypertension. An estimated 20 million Americans currently suffer from the disease. A recent report in the *Journal of the American Medical Association* of a study conducted among nearly 23,000 adults employed in the Chicago area revealed that most who had high blood pressure did not know of their condition and that few of those who



knew about it were receiving adequate treatment.¹ The editors of the journal urged doctors to "take a more responsible view toward [this] treatable illness."²

A growing body of evidence suggests that prompt detection and treatment substantially lower the risk of serious complications. Toward that end, the creation and funding of a National Hypertension Program were announced in 1972 by former Secretary of Health, Education and Welfare, Elliot L. Richardson.

Vital, growing role of pharmacist

Dr. Theodore Cooper, Director of the National Heart and Lung Institute, which is the focal point for coordinating the activities of this program, views the pharmacist as contributing to its success "both in his capacity as an actual 'health educator' and advisor to the public and in his capacity as a colleague of the prescribing physician."³

MERCK SHARP & DOHME recognizes the vital role played by pharmacists in any therapeutic regimen and is pleased to have brought you this information. We offer our continuing support in keeping you abreast of developments in several medical fields, including the treatment of hypertension.

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A LEADER IN CARDIOVASCULAR MEDICINE

1. Schoenberger JA, Stamler J, Shekelle RB, Shekelle S: Current status of hypertension control in an industrial population, *JAMA* 222:559, Oct 30, 1972.

2. Hypertension: A neglected phenomenon, editorial. *JAMA* 222:579, Oct 30, 1972.

3. Cooper T: The National Hypertension Program, *J Am Pharm Assoc NS13*:135, March 1973.

Last Tuesday Jack Lambert got annoyed with his pharmacist.

Jack was anxious to have his prescription filled fast because his son was pretty ill, and he was worried about him. So when his pharmacist paused a long minute before handing over the medicine Jack demanded, "What are you doing?"

"I am double checking your prescription, Mr. Lambert. The dosage, the instructions, the medication itself. Especially since our records show your boy has an allergic reaction to several substances. I hope he's up

and around soon."

Jack stopped being annoyed and felt appreciative once he realized he was simply benefiting from the thorough professionalism of his pharmacist.

It's part of the combination of professional efforts from everyone involved in delivering good health: Your personal physician, your personal pharmacist, and the companies who manu-

facture your medicines.

So next time your pharmacist stops to check—be glad. It's a wait that's worth it.



The Pharmaceutical Manufacturers Association

Send for our free booklet, "When It Comes to Rx Medicines There Are A Lot of Questions You Should Ask." It'll give you a lot of answers. Write to The Pharmaceutical Manufacturers Association, Dept. NW-6, 1155 Fifteenth St., N.W., Washington, D.C. 20005.

*This ad is currently
appearing in
Newsweek magazine.*

Professionalism. It's worth a little explanation.

You expect professionals to be competent. Even dedicated—like the pharmacist on the opposite page.

After all, being a professional implies a high level of training and proficiency. Professionalism is also a matter of teamwork and attitude.

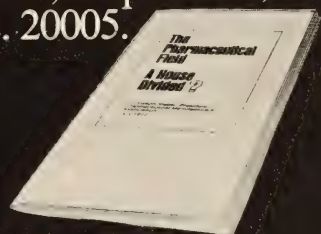
Take today's health care system. Medicine, pharmacy and manufacturer. Probably the most accomplished group of professionals that's ever worked together.

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We happen to believe ours is an inseparable system. And one that has provided the public with more effective, safer medication than any alternative system that could be devised.

We also believe that establishing a healthy dialogue among us is the professional way to smooth out any problems.

We think the PMA has opened the door for some good healthy interaction. For example—the activities of our Pharmacy Relations Committee. And the publication of "The Pharmaceutical Field, A House Divided?" It pulls no punches. For a free copy write to: The Pharmaceutical Manufacturers Association, Dept. PA-6, 1155 Fifteenth St., N.W., Washington, D.C. 20005.



Washington Spotlight For Pharmacists

By
APhA Legal Division

Drug Advertising and Promotion

In recent hearings before Senator Gaylord Nelson's (D-Wisconsin) Select Committee on Small Business, witnesses discussed the effect of drug advertising and promotion on physicians' prescribing decisions. Two witnesses placed special emphasis on the allegation that the pharmaceutical detail man is a potential source of misleading information to the physician.

Dr. Paul D. Stolley of the Department of Epidemiology at Johns Hopkins University testified that, over the past several years, he has carried out an investigation of the effect of drug advertising on physicians' prescribing habits. The community in which the study was performed is located in the Eastern part of the United States and has a population of over 100,000 persons. About 100 doctors serve this population and about a quarter of a million prescriptions were ordered by them during the year of the investigation.

One of the main objectives of Dr. Stolley's study was to examine chloramphenicol prescribing in the community because he believed this would be an indicator of the quality of prescribing practices in the community as a whole and by individual physicians. Dr. Stolley's reasoning for choosing chloramphenicol is that this drug has been recognized for over ten years as a cause of aplastic anemia, a blood disease in which the body does not produce red blood cells. For this reason, the labeling for chloramphenicol states that the drug should be prescribed only for certain serious and life threatening infections such as typhoid fever and Rocky Mountain spotted fever.

No cases of typhoid fever were reported during the time of Dr. Stolley's study. However, the study revealed that chloramphenicol was prescribed frequently by some physicians. The physicians who prescribed chloramphenicol for illnesses for which it was not recommended were characterized by the study as "less appropriate" prescribers. According to the study, those physicians who were willing to prescribe chloramphenicol for trivial infections also tended to use certain vitamins for the treatment of anemias that do not respond to such therapy, amphetamines for the treatment of obesity, and psychomotor stimulants as a "tonic" for many elderly patients.

After his survey was completed, Dr. Stolley concluded that the problem of "less appropriate" prescribing lies in large part with the system of marketing and advertising which influences the physician. Dr. Stolley noted that the less appropriate prescriber was more apt to have a favorable view of the pharmaceutical industry and particularly of pharmaceutical detail men, generally trusting the information he received from detail men and looking forward to their visits. The physicians who prescribed chloramphenicol in large amounts tended to have

an unfavorable view of the FDA and seemed to oppose any governmental regulation of prescribing or of the drug industry. Further, the less appropriate prescriber was more likely to hear about drugs through drug advertisements or the detail men rather than a journal article or a medical meeting.

Dr. Harry F. Dowling, a former Chairman of the Council on Drugs of the American Medical Association, added additional information to support Dr. Stolley's contention that the problem of less appropriate prescribing lies primarily with the system of marketing and advertising of drugs. Dr. Dowling stated that, although the accuracy of information reaching the physician has improved greatly in recent years, in his view the activities of the detail men are still a problem. Dr. Dowling noted that the FDA can monitor printed advertisements in journal articles or advertisements sent by direct mail, but it is impossible for the FDA to adequately monitor the thousands of conversations that take place daily between the detail men and physicians. Yet the detail man, according to Dr. Dowling, can negate much of the improved information that is reaching physicians today. Dr. Dowling stated: "... I have reviewed all the studies I could find in the literature on the influence of detail men on prescribing habits of physicians and found that the detail man was the source of the first information about a new drug for 31 to 52 percent of the doctors in different studies. Also, detail men were responsible for persuading doctors to use a new drug from 21 to 67 percent of the time." From prior testimony given before the Select Committee on Small Business, Dr. Dowling noted that there is good evidence that therapeutic claims are exaggerated and toxic reactions minimized by detail men.

Both Dr. Dowling and Dr. Stolley agreed that more unbiased, readable, and practical information should be available to physicians and that drug advertising should be more stringently regulated. In this regard, the State of California has taken steps to curb promotional abuses by detail men by enacting legislation prohibiting the furnishing of complimentary drug samples without a written request from the prescriber. Also, a bill recently introduced in Congress by Senator Nelson provides in part: "... no drug salesman shall make any oral presentation regarding any drug until he has placed before the physician or pharmacist an FDA approved document about the drug."

According to the latest figures presented by Senator Nelson, the prescription drug industry spends more than \$1 billion annually on advertising and promotion. Assuming the accuracy of this figure, approximately \$5,000.00 is being spent per year on each physician to persuade him to prescribe particular drugs. Senator Nelson and others contend that, of this sum, more than 85 percent is economic waste. Therefore, it can be expected that these continuing attempts to enact legislation will be to curb these alleged excesses by restricting the influence of advertising and detail man promotion on the prescriber.



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SUMMARY OF STATEMENTS AND RECOMMENDATIONS MADE TO THE HEALTH PROFESSIONS BY THE COMMISSION ON MARIHUANA AND DRUG ABUSE

The Commission on Marihuana and Drug Abuse has recently issued its final report. The report examines the roots of the drug problem in the United States and recommends policy directions for both the public and private sectors. The following summarizes the statements and recommendations made to all health professions and specific statements and recommendations made to pharmacists and pharmaceutical manufacturers.

The Health Professions

The Commission encourages all physicians to recognize the dangers inherent in the use of psychoactive drugs. The problem is not primarily the unscrupulous physician, but the well-intentioned physician who, insufficiently aware of the risks, prescribes and re-prescribes where the use of the drug is not indicated. Inappropriate prescribing practices unfortunately develop easily. Overworked and pressured by patients, the physician too often renews a prescription without adequate opportunity to confirm its continued need.

The Commission strongly recommends that the medical profession prepare criteria for use of all psychoactive drugs in medical practice. All health professions have the responsibility to develop a general ethic for therapeutic use of psychoactive drugs. This ethic would govern not only prescribing practices by physicians, but also the way in which all members of the health professions and the public approach the medical use of these drugs. It would apply to both prescription and over-the-counter or proprietary drugs. The ethic should emphasize the dangers in repeated and heavy use of any drug, the risk in allowing self-medication to delay a resort to professional health services, and the undesirability of resorting to drugs to cope with minimal anxiety, stress and depression.

At present, professional schools in medicine or other health services give the treatment of drug problems only incidental notice in the curriculum. Unless the schools show more concern for the health problems caused by drug-using behavior, many of their graduates will be unprepared, and therefore unwilling, to deal with drug dependent persons in practice. Therefore, the Commission recommends that schools of medicine, pharmacy, nursing, and public health include instruction dealing with the social and medical aspects of psychoactive drug use. This instruction should inform health professionals of the problems and possibilities of treating drug use and dependence as well as the wider social implications of both licit and illicit drug use.

Pharmacists

Pharmacists should take a positive role in dealing with all drug consumption as well as preventing diversion of drugs for illicit purposes. For many years, neighborhood pharmacies dominated distribution of pharmaceuticals within the community; the pharmacist knew his cus-

tomers personally and often advised them on their use of medicines. Today, as a result of many factors, including the mass merchandising techniques of chain pharmacies, society has forfeited many services which the profession most learned in the properties of drugs can render.

Therefore, the Commission recommends that steps be taken to reinvolve the community pharmacist in the drug consumption decision, particularly with respect to psychoactive substances. At the very least, pharmacists should be prepared and encouraged to make their patients fully aware of the risks in the use of these drugs, and pharmacists should advise the prescribing physician when his choice is questionable. Pharmacists should also counsel patients on the use of proprietary psychoactive substances, taking the precaution of having those products available only at the prescription counter.

The Pharmaceutical Manufacturers

With its remarkable post-war expansion in size and research effort, the pharmaceutical industry has also adopted more aggressive marketing practices. Research required investments which companies were anxious to recoup before the patents on the new discoveries expired. Since consumption choices in the prescription drug industry are made not by the drug user but by his physician, drug companies focused promotional efforts on the nation's practicing physicians.

Physicians obtain information on prescription drugs in a variety of ways. Their primary sources include journal articles, colleagues, detailmen, advertising, the *Physicians' Desk Reference*, and pharmacists. Still, the manufacturer is the primary source of information behind all of these sources. The problem of advertising and information is particularly acute with respect to psychoactive substances. Pharmaceutical companies promote the use of these drugs to deal with patients' complaints of tension and anxiety. Patients often know about the drugs and ask that they be prescribed. Because stress-related complaints are now so common and tranquilizing drugs often seem the only quick way to provide relief, physicians find it difficult to resist the blandishments of the manufacturers and the demands of his patients.

The Commission recommends that manufacturers of psychoactive substances undertake a major campaign to educate both health professionals and the public about the appropriate therapeutic role of these drugs. Information and advertising aimed at physicians should point alternative therapies and plainly disclose harmful side effects, risks of prolonged use, and dangers of drug combinations, including alcohol. In non-technical language, a series of public service advertisements should carry the same message to the lay public.

The Commission also recommends that pharmaceutical manufacturers cease the practice of sending physicians unsolicited samples of psychoactive drugs. Having free drugs on hand may encourage physicians to administer those drugs too readily. The controlled substances law prohibits sample distribution of controlled drugs except on specific written request by the physician. Manufacturers should voluntarily extend this practice to non-controlled psychoactive products.

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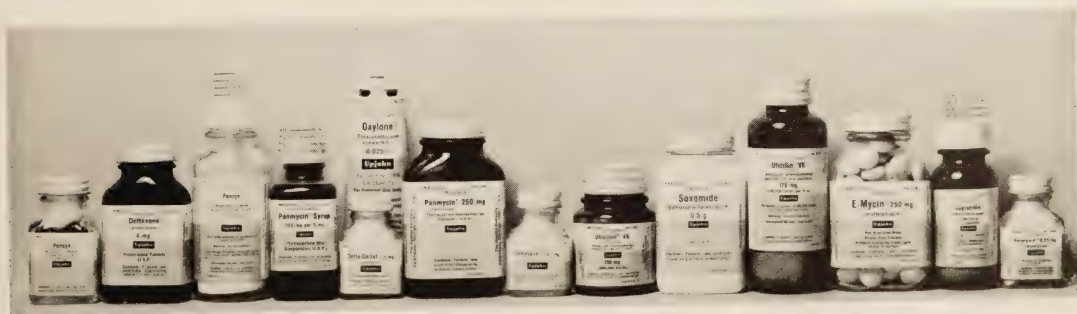
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Pharmacy Ownership Statute Before United States Supreme Court

The United States Supreme Court will rule on the constitutionality of a North Dakota statute which requires the majority of stock in a corporation-owned pharmacy be held by pharmacists responsible for the management and operation of the pharmacy. The Supreme Court has agreed to review the case of *North Dakota State Board of Pharmacy v. Snyder's Drug Stores, Inc.* A decision upholding the North Dakota statute could have immeasurable impact on the pharmacy profession.

The appeal to the United States Supreme Court is taken by the Board of Pharmacy from an adverse decision by the North Dakota Supreme Court. The state supreme court held that it was bound by *Liggett Company v. Baldridge*, a 1928 decision of the U. S. Supreme Court. In the Baldridge case, the U. S. Supreme Court had considered a Pennsylvania statute which required, in the case of corporations, associations, and copartnerships, that all the "partners" be licensed pharmacists. The U. S. Supreme Court agreed that a state may regulate pharmacy practice by appropriate legislation to the extent reasonably necessary to protect the public health. However, as the act under review dealt with pharmacy ownership, the U. S. Supreme Court held that the Pennsylvania law:

"plainly forbids the exercise of an ordinary property right and, on its face, denies what the Constitution guarantees. A state cannot, under the guise of protecting the public, arbitrarily interfere with private business or prohibit lawful occupations or impose unreasonable restrictions upon them . . . [The] mere stock ownership in a corporation owning and operating a drug store can have no real and substantial relationship to the public health; and . . . the act in question creates an unreasonable and unnecessary restriction on private business. No facts are presented by the record and, so far as appears, none were presented to the legislature which enacted the statute, that properly give rise to a different conclusion."

Justices Holmes and Brandeis dissented from the majority opinion. According to Justices Holmes and Brandeis:

"A standing criticism of the use of corporations in business is that it causes such business to be owned by people who do not know anything about it. Argument has not been supposed to be necessary in order to show that the divorce between the power of control and knowledge is an evil . . . The Constitution does not make it a condition of preventive legislation that it should work a perfect cure. It is enough that the questioned act has a manifest tendency to cure or at least make the evil less."

The North Dakota State Board of Pharmacy asserts that the North Dakota statute is a valid exercise of state power as the requirement of pharmacist ownership and participation in the corporate controlled pharmacy does bear a real and substantial relation to the public health,

safety, and general welfare. Further, the Board submits that the North Dakota Supreme Court erred in holding that it was bound by the 1928 Baldridge decision, citing subsequent cases which it argued either reverse or substantially weaken the Baldridge decision. To sustain this conclusion, the Board cites a 1963 United States Supreme Court decision which states in part:

"There was a time when the Due Process clause was used by this court to strike down laws which were thought unreasonable; that is unwise or incompatible with some particular social or economic philosophy . . . This intrusion by the Judiciary into the realm of legislative value judgments was strongly objected to at the time by Mr. Justice Holmes and Mr. Justice Brandeis. The doctrine that prevailed in (earlier cases) that due process authorizes courts to hold laws unconstitutional, when they believe the legislature has acted unwisely, has long since been discarded. We have returned to the original constitutional proposition that courts do not substitute their social and economic beliefs for the judgment of legislative bodies, who are elected to pass laws."

The quoted decision represents a change in emphasis and philosophy of the U. S. Supreme Court. However, as the Supreme Court decides each case on its own merits and as several Justices have retired since the 1963 decision, it would be purely speculation to attempt to predict the outcome of the pending appeal of the North Dakota case.

Azoans Install New Officers

The Azoans installed the following new officers for 1973-1974 at the Mercantile Club on June 13. Installed were: Mrs. George Stiffman, as President; Mrs. Morris Bloom, First Vice President; Mrs. Morris Levin, Second Vice President; Mrs. Jerome Stiffman, Recording Secretary; Mrs. Morton Cohen, Corresponding Secretary; Mrs. Harry Rudie, Financial Secretary; Mrs. Harry Greenberg, Treasurer; Mrs. Nathan Pelovitz, Chaplain; and Mrs. Myer Stoler, Custodian.

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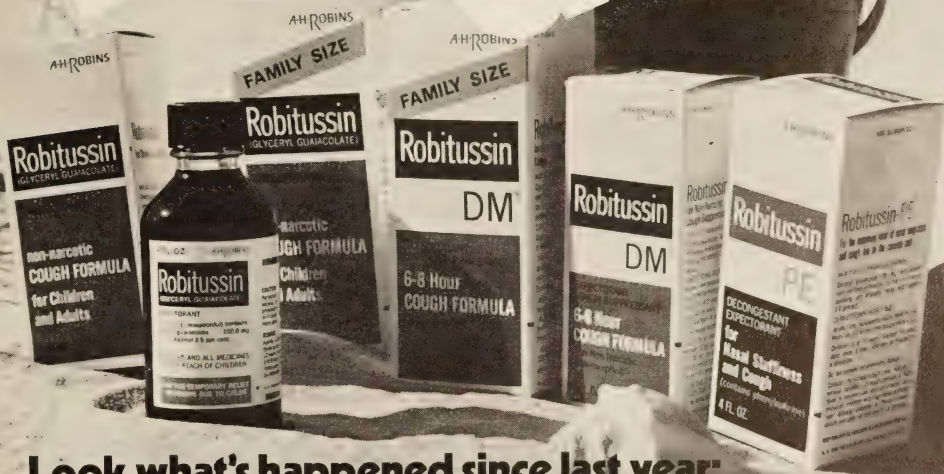
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New Portable Data Unit Provides Store Operators With Means To Receive Ordered Merchandise From Wholesaler Within 48 Hours

An incredible time-saver for placing orders, receiving merchandise and keeping a fast, accurate count on hundreds of shelf items, has been unveiled by the Ford Hopkins Company, drug and sundry wholesalers and creators of the Sun Discount Drug Chain, presently operating in some 10 mid-western states. According to drug store managers and other data observers, the system is certain to revolutionize the wholesaler-retailer system and greatly ease the plight of many stores in solving problems of turnover and inventories throughout the world.

This time-saver unit is the MSI Source 2001 Portable Data Terminal which was recently developed by the MSI Data Corporation. The unit is basically a sophisticated electronic programmer of recording coded data at the store owner's own pace which is fed into a unit that can transmit orders at fantastic speeds via regular telephone lines. No special telephone equipment is necessary.

The portable, lightweight data terminal consists of three basic parts: a hand-held keyboard for data input which transmits into a magnetic tape cassette in the recorder module. After the data has been transmitted into the cassette, the operator merely dials the wholesaler's 24-hour operational unit department, informs them of the order being placed, puts the telephone receiver in a transmitting module on his desk and in 30 seconds his order is recorded for instant processing and subsequent delivery.

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Obituaries

Anthony J. Kursvietis

Anthony J. Kursvietis, 54, member of the Maryland Pharmaceutical Association and Baltimore Metropolitan Pharmaceutical Association, died on May 23. He was a 1940 graduate of the University of Maryland, School of Pharmacy.

Leroy Oldham

Leroy Oldham, 98, former proprietor of Leroy Oldham Drug and Chemical Company, died on May 22.

Frank J. Macek

Frank J. Macek, 76, Past President of the Maryland Pharmaceutical and Baltimore Metropolitan Pharmaceutical Associations, died on June 19 at St. Agnes Hospital after a long illness. Mr. Macek who retired in 1968 was on the Board of Directors of the Calvert Drug Company and served as secretary-treasurer for 20 years.

Martin Kessler

Martin Kessler, former member of the Traveler's Auxiliary of the Maryland Pharmaceutical Association, died on June 16. He was a partner in the H. T. Madden Company, a manufacturer's agent firm.

John S. Austerlitz

John S. Austerlitz, 83, died on June 21. He was a 1913 graduate of the University of Maryland, School of Pharmacy.

Dr. Francis J. Januszkeski

Dr. Francis J. Januszkeski, 60, died on June 28. He graduated from the University of Maryland, School of Pharmacy, in 1934 and from the School of Medicine in 1938.

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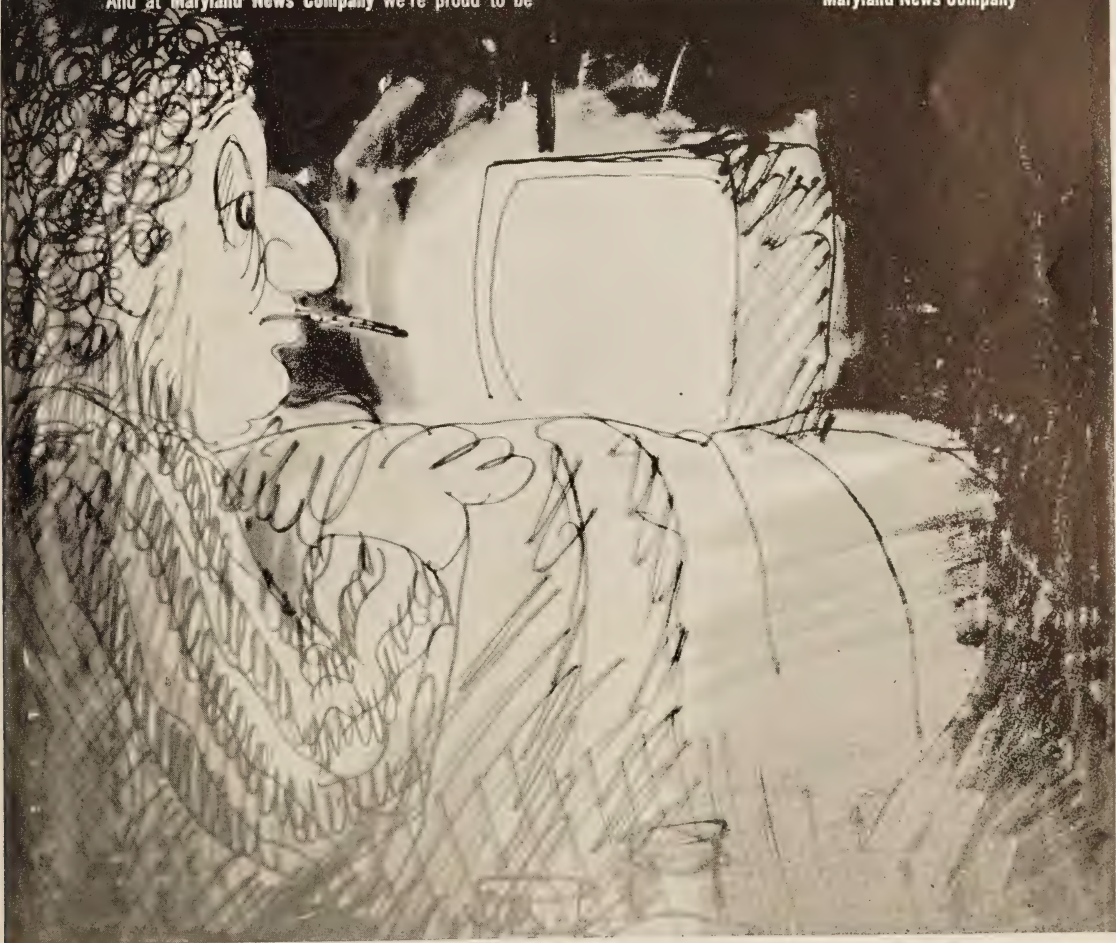
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the maryland pharmacist

JULY
1973
Volume 49
Number 7



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MPhA President Anthony G. Padussis, center, discusses plans for coming year with Nathan I. Gruz, left, Executive Director and Paul Freiman, President Elect.

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VO prevention news

"OPEN DISPLAY" OF CONDOMS KEY TO V.D. BATTLE

Since they began to appear on the pharmacy scene two years ago, over 10,000 Trojans prophylactics display units have been distributed to drugstores in the 42 states where this is allowed. And...Youngs Drug Products Corporation predicts that point-of-sale prophylactic racks may well pass the 20,000 mark in the next two years.



Increased condom sales are being reported everywhere by pharmacies that have installed Youngs "open display" rack. "Open Display" makes prophylactic sales far easier for both clerks and buyers (an increasing number of which are women).

According to Youngs:

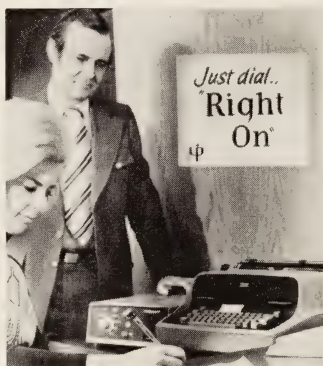
- Open display is not merely "accepted" by the public—it has been welcomed "with opened arms."
- Displays have directly accounted for increased sales of up to four times.
- Open displays have become doubly effective. One—they emphasize that condoms are effective aids in the prevention of V.D. Two—they also prevent unwanted pregnancies and aid in family planning.
- Display racks are now legal in every state except New York, Arkansas, Idaho, Michigan, South Dakota, Massachusetts, Utah and Wisconsin.

Youngs Drug Products Corp. as well as enlightened legislators, doctors, and pharmacists everywhere agree that if we are to

prevent V.D.—which is now the most prevalent communicable disease next to the common cold—there must be open display of the primary device that can control it.

YOUNGS "RIGHT ON" WITH RADIO

In the first condom commercials ever aired on radio, Youngs Drug Products Corp. used the popular catch phrase "Right On" to help spur the sale of Trojans Brand prophylactics. At the tail end of each of three 30-second spots, listeners were advised to phone by dialing the letters R-I-G-H-T O-N. The idea being it would be lots easier to remember



It was Youngs president John C. MacFarlane who thought of using the catch phrase "Right On." Here he is standing by to help monitor the phone company's tape recorder.

a phrase than seven digits (especially if you happened to be driving a car and did not have access to a telephone).

The Youngs taped voice at the other end of "Right On" asked each caller to give name and address in order to obtain an informative product brochure. In the 10 week period the spots were run, the company received thousands of calls and callers were advised to obtain future Trojans from their pharmacist.

STATE BY STATE V.D. AWARENESS CAMPAIGNS SCORE BIG FOR PHARMACY

Over the past three years, V.D. prevention campaigns, staged by Youngs Drug Products and a large number of state pharmaceutical associations, have been putting the focus on V.D. awareness. Employing the strategy that "the more attention given a problem, the more can be done to solve it," Youngs aggressive publicity program has been putting V.D. prevention in the limelight. So far this year, separate V.D. awareness projects have been



Mel Clark, Sales Manager, Youngs Drug Products Corp. (left), pharmacist Mario Casinelli (center) and TV interviewer Marie Ann DeNunzio discuss the open display of condoms on a WPRI, Channel 10 newscast in Providence, Rhode Island.

carried on in Rhode Island, New Mexico and Michigan. Soon to come are programs in New Jersey, Oklahoma and Connecticut, with many more to follow.

An excellent example of the kind of press and TV publicity that can be generated was the Rhode Island program. Aided by super-active pharmacist-chairman Mario Casinelli, a well conceived V.D. conference received saturation press coverage as well as television pickup on WPRI, Channel 12 and WJAR, Channel 10 in Providence. The latter consisted of a full half hour program devoted to discussion of V.D. prevention, open display of condoms, and the importance of pharmacy handling.

Produced by Youngs Drug Products Corporation

Manufactured at Trojan Brand Quality Prophylactics, 865 Centennial Avenue, Piscataway, New Jersey 08854.

The Maryland Pharmacist

NATHAN I. GRUZ, *Editor*
NORMAND A. PELISSIER, *Assistant Editor*
ROSS P. CAMPBELL, *News Correspondent*
HERMAN J. BLOOM, *Photographer*

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HOW MANY CLASSES OF DRUGS?

Is The Public Adequately Protected?

Is the public interest regarding the distribution of medication being adequately protected by classifying all drugs into two major groups: prescription and non-prescription (OTC) drugs?

Should there be a third class of drugs, available only from a pharmacist or in a pharmacy?

There are at present, of course, some OTC drugs available only from pharmacists. These are the "poisons," which are almost things of the past, and "exempt narcotics" (in some counties).

It should be pointed out that the Constitution of the Maryland Pharmaceutical Association includes under "Object of Association: . . .

". . . to prevent the adulteration, abuse and misrepresentation of drugs and medicines and to confine the compounding and sale of drugs and medicines to duly educated and licensed pharmacists."

The time is overdue for a reexamination of the issue. The growing evidence of the hazards of advertising, promoting, merchandising and selling OTC drugs as mere ordinary articles of commerce demands action by all interested in the public health and welfare.

Many are convinced that the cavalier attitude toward "patent medicines" and prescription drugs have contributed to molding the current public predilection to drug abuse and misuse.

On October 11, 1973, the Maryland Pharmaceutical Association will devote the Fall Regional Meeting to an examination of the issues involved in the unrestricted sale of OTC drugs. The pharmacist, the pharmaceutical scientist, the drug industry and the consumer will have opportunities to contribute to the afternoon's discussion.

From this program an agenda for future action—perhaps legislation—will come.

We hope all pharmacists and others interested in safeguarding public health will attend the MPhA Fall Regional Meeting and contribute to constructive change in the distribution of "OTC" drugs.

—Nathan I. Gruz

October 11—MPhA Fall Regional Meeting and House of Delegates, Thursday, October 11, 1973, Cross Keys Inn—Baltimore.

October 14-19—National Association of Retail Druggists Annual Meeting, Portland, Oregon.

October 24 (Wednesday)—Prince Georges-Montgomery County Pharmaceutical Association General Meeting, Old Bemar Pharmacy Hall, Silver Spring, Md. 10:00 p.m.

November 4-6—International Federation of Catholic Pharmacists 12th Congress, Mexico City, Mexico.

November 8-11—American Society of Consultant Pharmacists Annual Meeting, San Francisco, California.

November 18 (Sunday)—Prince Georges-Montgomery County Pharmaceutical Association 19th Annual Scholarship Affair, Harlequin Dinner Theater, 7:00 p.m.

December 9-13—American Society of Hospital Pharmacists Midyear Clinical Meeting, New Orleans, Louisiana.

1974

February 18-24—Maryland Pharmaceutical Association "Holiday in Israel" with optional extension tour to Rome.



The Pharmacist—Partner in the Health Care Team

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MPhA In Action

Board of Trustees Meetings

NATHAN I. GRUZ, *Executive Director*

June 14, 1973

—Noted receipt of copy of letter from the School of Pharmacy Alumni Association to the School of Pharmacy acknowledging the award of a scholarship by the Maryland Pharmaceutical Association.

—Approved President's report noting activities of the Medicaid and Peer Review Committees. Also noted attendance at meeting on Peer Review with State Medicaid Program officials. Reported on a meeting with State Police, accompanied by Delegate Sklar and Mr. Gruz, on security problems. An educational program for presentation at the MPhA Convention was agreed on.

The President also reported on the excellent Workshop on the Pharmacist's Role in Family Planning and on the State Health Department investigation of nursing home pharmacy services.

—Approved Treasurer's report.

—The Executive Director reported on the following activities: Convention trip to Spain, Workshop on Family Planning, meeting with State Police, Peer Review Committee, Third Party Programs, BMPA meetings, Convention Committee and Board of Pharmacy. Also attended meetings of the Maryland Society of Association Executives, Maryland Health Maintenance Committee, and Affiliated State Pharmaceutical Association Executives at APhA.

—Received report of the Speaker of the House of Delegates. Mr. Seidman announced that a letter was sent out to all Delegates regarding attendance at meetings of the House of Delegates. He also noted that as Chairman of the BMPA Committee on Pharmacy Public Information requests had been mailed out to all radio and TV stations for program time.

—Heard Convention Committee report. The Convention Trip Chairman reported on the Spain trip which was attended by 158 persons. He stated a trip to Israel planned for February 18-28, 1974 would be limited to 80 and had resulted in a great deal of interest. It was agreed to have the committee look into a possible non-charter trip in May, with Mr. Schwartz and Mr. Simon as Co-Chairmen. Convention Committee Chairman Padussis outlined the program for the Hunt Valley Convention.

—Received report of the Prescription Insurance Program Committee noting informational mailing that is planned on all Third Party Payment Plans. The Board voted that MPhA oppose any third party program policies requiring the furnishing of blank prescription forms to patients.

—Heard report on Board of Pharmacy noting that Mr. Tregoe, who was recently appointed to the Board, was elected Secretary of the Board.

—Heard report on formation of the Anne Arundel County Pharmaceutical Association. The Board voted to appropriate \$250. to aid in establishing the new association. The Board also voted to grant affiliation status to the new group.

—Discussed the problems connected with the use of temporary eligibility cards in the Medicaid program. Secretary Gruz noted that Dr. Tayback advised him that the State would be making an announcement regarding resolution of the problems of temporary cards.

—Decided not to participate in the Maryland Food Committee program.

—Referred to the House of Delegates the matter of criteria for considering applications for membership from pharmacists who are not in violation of the law.

—Approved the Peer Review Committee Guidelines as drafted by the Peer Review Committee.

—Referred to the House of Delegates the matter of continued APhA participation in NPIC.

June 30, 1973

Hunt Valley Inn

—Approved for recommendation to the House of Delegates as nominees for appointment to the Maryland Board of Pharmacy: Ralph T. Quarles, Robert E. Snyder and Harry Wille.

—Endorsed the majority report of the APhA Committee on Organizational Affairs for continuation of APhA in NPIC.

New Members

The following is a list of the new members approved at the June 14, 1973 meeting of the Board of Trustees of the Maryland Pharmaceutical Association:

Claude E. Foggie, People's Drug Stores

Russell O'Connor, Drug Fair

R. D. Bennett, Peoples Drug Stores

David A. Dunn, Drug Fair



Legend drugs in their own time

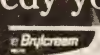
There's a time to listen, and a time to tell.

At Gilpin, we feel the time to listen is most of the time. Listening to you—our customers—your needs, your problems and occasionally your complaints.

And after we've listened, we set out to satisfy your needs, solve your problems and remedy your complaints.

But at Gilpin, we also feel there's a time to tell—to tell you thanks, we appreciate your business.

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GILPIN
COMPANY

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Maryland Board of Pharmacy News

Pharmacy Changes

The following are the pharmacy changes for the month of June:

New Pharmacies

Valley Professional Pharmacy, Inc., Howard Sherman, President; 9177 Reisterstown Road, Owings Mills, Maryland 21117.

Drug Fair No. 158, Milton L. Elsbarg, President; 1421-25 Rock Spring Road, Bel Air, Maryland 21050.

No Longer Operating As Pharmacies

Peabody Pharmacy, Thorpe T. Dawes, 2941 North Calvert Street, Baltimore, Maryland 21218.

Dolfield Pharmacy No. 2, Inc., Howard Pollack, President; 5024 Park Heights Avenue, Baltimore, Maryland 21215.

Ansell Pharmacy, Herbert C. Cook, President; 24 East Madison Street, Baltimore, Maryland 21202.

Changes of Ownership, Address

Fairway Pharmacy, Stanley L. Goldberg, President (Change of ownership); 531 Dale Drive, Silver Spring, Maryland 20910.

Bemar Pharmacy, Jackson G. Carney, President (Change of ownership); 9309 Georgia Avenue, Silver Spring, Maryland 20910.

Stansbury Pharmacy, Howard S. Surell (Change of ownership and pharmacy name); 1709 Poplar Place, Baltimore, Maryland 21222.

The following are the pharmacy changes for the month of July:

New Pharmacies

Provident Comprehensive Neighborhood Health Center, George L. Russell, Jr., President; 907 Edmondson Avenue, Baltimore, Maryland 21223.

No Longer Operating As Pharmacies

Charles Street Pharmacy, L. Handelman and G. Stiffman, 1001 North Charles Street, Baltimore, Maryland 21201.

Changes of Ownership, Address

Columbia Hospital and Clinics Foundation, Inc., Robert M. Heyssel, MD, President (Change of address); Little Patuxent Parkway and Cedar Street, Columbia, Maryland 21044.

Levy's Medicine Shoppe, Maurice T. Cummings, President (Change of ownership and pharmacy name); 8228 Fort Smallwood Road, Baltimore, Maryland 21226.

G and G Drug Store, Inc., Joseph F. Getka, President (Change of address); 7200 North Point Road, Edgemere, Maryland 21219.

Registrations Granted

The Maryland Board of Pharmacy, after canvassing the grades made in the examinations conducted by the Board June 19, 20 and 21, announced that registration will be granted to the following:

Lawrence Aiken	C. E. Leary
M. D. Allen	E. M. Ledrich
James D. Babb	Donna S. Levin
G. F. Bachman 3rd	David A. Lewis
D. S. Bialek	Stephen G. Lewis
M. S. Blumberg	N. Carolyn Love
Barry Bookoff	W. H. Lynch
Linda W. Bosco	A. F. Mansour
S. P. Boykin	J. T. McGrath
J. E. Cannon	K. W. Meagher
A. E. Clayman	R. P. Mierisch
David B. Creek	H-O Thi Nguyen
David A. Custer	D. R. O'Brien
Richard E. Davis	T. F. O'Connor
Charles R. Downs	R. D. Parker, Jr.
Patrick M. Dunn	S. B. Pelovitz
C. H. Eskridge	M. J. Peters, Jr.
M. J. Evanko, Jr.	S. T. Peters
J. S. Fannella	Joseph M. Ras
E. R. Feroli, Jr.	F. A. Royals
M. J. Foreman, Jr.	W. L. Salvatore
Merilyn J. Forti	James A. Sand
H. J. Goldberg	J. J. Sokol, Jr.
J. A. Goldberg	F. G. Statter
C. M. Gresser	R. G. Stride
G. J. Grimes, Jr.	A. C. Tommasello
Barry D. Hecht	Wasyl Tymuk
M. I. Herman	P. R. Webster
G. A. Ireland	D. L. Wessel
A. T. Johnson, Jr.	R. A. Wisniewski
J. L. Johnson 3rd	E. H. Yankellow
A. L. Kaplan	M. L. Yankellow
J. M. Kessler	

In addition, having previously passed the theoretical examination and having now passed the practical examination, registration will be granted to:

B. C. Barron	L. K. Homonnay-Preyer
F. M. Frankenfeld	T. B. Kulish, Jr.
James M. Gass	B. Vandenberg

The following passed the theoretical examination, but registration is withheld until they meet the legal requirements for practical pharmacy experience and pass an examination in practical pharmacy:

R. D. Biava	Garry J. Kelley
G. R. Bolger	John A. Kudrick
David M. Caplan	J. L. Marroco
F. L. Duncan	K. M. Meckley
Gregory Gawlick	Allan L. Schuss
G. E. Harrington	Gary M. Shafer
C. F. Hoffman	James M. Spear
M. A. Hoffman	

ANTHONY G. PADUSSIS

President, Maryland Pharmaceutical Association

Anthony G. Padussis graduated from the University of Maryland School of Pharmacy in 1944. During his military service, he served as chief pharmacist in a hospital. In 1948, he founded Edwards and Anthony Pharmacy with the late Edward J. Passaro. He served as President of the Baltimore Metropolitan Pharmaceutical Association in 1970 and as President of the University of Maryland School of Pharmacy Alumni Association in 1971-1972.

Mr. Padussis has been very active in the Maryland Pharmaceutical Association. He served two terms as Chairman of the MPhA Legislative Committee and is founder and Chairman of the Maryland Pharmacists Political Action Committee (PHARMPAC). He served as Chairman of the 1973 Convention and is Chairman of the MPhA Finance Committee. He also holds membership in the American Pharmaceutical Association and the National Association of Retail Druggists.

Mr. Padussis serves on the Board of Directors and is Treasurer of the Calvert Drug Company. He is an honorary life member of the Southeastern Improvement Association. Mr. Padussis is married to Arlene Padussis who currently is serving her second term as President of the Ladies Auxiliary of the Maryland Pharmaceutical Association and they have a daughter Annette, a student at the University of Maryland.



Paul Reznick (center), Silver Spring, Md. pharmacist, receives the A. H. Robins "Bowl of Hygeia" Award for outstanding community service by a pharmacist from Russell L. Barnes, district manager in the Capital Division of A. H. Robins Company. At right is Bernard B. Lachman, Past President of the Maryland Pharmaceutical Association.

OFFICERS AND MEMBERS OF BOARD OF TRUSTEES MARYLAND PHARMACEUTICAL ASSOCIATION - 1973-1974



—Photo by Paramount Photo Service

Officers and Members of the Board of Trustees, Maryland Pharmaceutical Association, 1973-1974 (l. to r. front row): Nathan I. Gruz, Executive Director; Paul Freiman, President Elect; Anthony G. Padussis, President; Morton Schnaper, Honorary President; Bernard B. Lachman, Chairman, Board of Trustees; (rear): Alder Simon, Vice Speaker, House of Delegates; James Truitt, Trustee; Stephen Hospodavis, Trustee; Melvin N. Rubin, Trustee; Henry G. Seidman, Vice President; Richard D. Parker, Trustee; S. Ben Friedman, Speaker, House of Delegates. Not present at time of photo were: Morris Lindenbaum, Treasurer; Melvin J. Sollod, Trustee, and Robert E. Snyder, Trustee.

Reznek Receives Bowl of Hygeia Award

Silver Spring pharmacist Paul Reznek has been honored by the Maryland Pharmaceutical Association as its 1973 recipient of the A. H. Robins "Bowl of Hygeia" Award for outstanding community service. Mr. Reznek, a pharmacist at Drug Fair, received the award July 1 during the association's 91st Annual Convention in Cockeysville.

Mr. Reznek, who received his degree in Pharmacy from Temple University, has been active in several fund drives in the Silver Spring area and is a leader in metropolitan Washington pharmaceutical associations. He is a member of the American Pharmaceutical Association and of the Maryland Pharmaceutical Association, Editor of the Prince Georges-Montgomery County Pharmaceutical Association publication, the *Bi-County Pharmacist*, is a past Associate Editor of the *National Capital Pharmacist* and a former Assistant Editor of *The Maryland Pharmacist*.

He has been a member of the D.C. Pharmaceutical Association since 1930, having served as President in 1947. He received an NARD-Lederle Award for Inter-professional Services Honorary Mention in 1971. He serves on the NARD Committee on Government Affairs. Mr. Reznek is a director of the Metropolitan Guild of Pharmacists and was a recipient of the AZO "Order of

the Double Star" Award for Meritorious Service. He has been a National Legislative Representative for Alpha Zeta Omega Pharmaceutical Fraternity.

The Bowl of Hygeia, most widely recognized international symbol of pharmacy, derives from Greek mythology. Hygeia was the daughter and assistant of Aesculapius (sometimes spelled Asklepios), the God of Medicine and Healing. Her classical symbol was a bowl containing a medicinal potion, with the serpent of Wisdom (or guardianship) partaking of it. This is the same serpent of Wisdom which appears on the caduceus, the staff of Aesculapius which is the symbol of medicine.

The "Bowl of Hygeia" Award, presented annually through the Maryland Pharmaceutical Association, is a handsome mahogany plaque measuring 10 by 13 inches and featuring the Bowl of Hygeia cast in bronze. It is modeled after a sterling silver bowl made by a Mexican silversmith and given to the A. H. Robins Company by its Latin American representatives in 1953 on the Richmond (Va.) ethical pharmaceutical manufacturing firm's 75th anniversary.

An appreciation of the time and personal sacrifice devoted by pharmacists to the welfare of their respective communities prompted E. Claiborne Robins, chairman of the board and chief executive officer of the company, to establish the award in 1958. It is now presented annually by participating pharmaceutical associations in each of the United States, the District of Columbia, Puerto Rico and the provinces of Canada. The recipients are selected by their respective associations.

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The Calvert Drug Company

1973 Statistical Report

Maryland Poison Information Center

Introduction:

The Maryland Poison Information Center (MPIC) has completed its seventh full year of operation and its first year at the School of Pharmacy (University of Maryland). With cooperation from departments and individual faculty within the University complex, the Center has begun to reach a larger population and increase the support it could offer to the community. Several projects have been undertaken during this period in order to better evaluate the effectiveness of the MPIC's ability in reaching the needs of this state in the areas of information, treatment, education and training on various aspects of poisonings.

During 1972, the MPIC received a total of 8,223 calls which was the majority of the calls that the state received through the poison centers (as seen in Table II). Of these 8,223 calls, 5,675 calls involved some kind of an ingestion or contact, the remaining calls being primarily for information. Over the last seven years of the MPIC's operation, it has always received at least 50 per cent of all the calls for the state, with this figure rising to 89 per cent of total calls in 1972. It is very possible that this escalation in number of calls received by the MPIC is due in part to more individuals making their initial call to the Center and less frequently visiting the emergency room. Since the data, especially from the city emergency rooms, has not been available this year, this can only be speculated. More clearly, though, it has been shown in the Baltimore County and Anne Arundel hospitals that although the number of ingestions noted by the Center has increased, there has been little change in the number of patients being seen in the emergency room:

	1971	1972
Baltimore County	871	979
Anne Arundel County	536	637

It is known, though, that physicians treat many patients within their office and no data from these individuals is forwarded to any center. Therefore, complete information even on the number of treated ingestions and poisonings is lacking.

Although there has been an overall increase in the number of calls received by the Center, the increase has been more noticeable in the younger (0 to 4 years) age groups. This shift to a higher proportion in the 0 to 4 age group is more similar to that noted in 1966 (see Table II). Several factors may have caused this shift:

1. More parents are aware of the Center's existence. The telephone company has published the number in the front of the phone book. The Center has reached the community through its speakers,

literature and publications. Word has also been passed from parent to parent.

2. Since the Center is now located within the University complex, potential suicide calls are being directed to the psychiatric services instead of to the Center.
3. With increased medical insurance, the older individual goes directly to the hospital for treatment.

The Center has shown at least within Baltimore County that the number of visits by the young child to the emergency room has decreased while the number of calls from that area has increased. The Center, therefore, is beginning to show increased ability to act as a front line to the parents with a child who has ingested. It is able to evaluate the child at home, to offer first aid measures when necessary, and to decrease unnecessary overcrowding of emergency rooms with patients who can easily be treated at home. Few of the children whose parents call us promptly need hospital treatment. Therefore, with increasing reputation of the Center, it is anticipated that more parents will use its services and fewer unnecessary hospital visits will be made.

* * * * *

Medicines continue to be the most frequently ingested substances in all age groups. Their availability to the younger age groups make them easily accessible for accidental ingestion, and in the older age groups for abuse and suicide attempts. Also, except for the high proportion of motor vehicle exhaust (CO) deaths in the counties, medicines caused the most deaths. Of the six deaths in children, four of these were from medicines (see Deaths 1972, Baltimore City and Counties of Maryland, p. 20). Barbiturates (excluding the narcotics) still lead the list having the highest potential for lethality. In addition, as one can see in Table I the proportion of ingestions of barbiturates in the 12 to 24 age group has almost doubled in comparison to 1971 figures, whereas there has been no such significant increase in any other category. This is the age group that has the highest frequency of both drug abuse and attempted suicide.

It is anticipated that with the law which requires the use of safety caps on all prescription medicines that there will be a decrease in the ingestion of these by the younger children. Further, with an increased awareness by the manufacturers of OTC drugs an increased use of safety closures for these products would be expected.

The next largest group of ingestions for 1972 were the household products, 82 per cent of which were again in the 0 to 4 year age group. The large majority of these ingestions were not considered poisonings. There were

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few which even warranted attention by a physician; those which did included caustics from drain and toilet bowl cleaners and electric dishwasher detergents.

The calls received in the pesticides and petroleum distillates category were, again, in the 0 to 4 year age group as the table on page 20 indicates. In both of these categories the major problem is the hydrocarbon. Although the treatment does not necessarily involve immediate emergency treatment, all these ingestions warrant evaluation by a physician. Pesticides that are ingested by children are generally those found within the home. Therefore, the active ingredient of the pesticide is found in minute quantities; and the inert ingredient, the hydrocarbon, is the major problem. There were several pesticide ingestions during 1972 which were more serious, and which were due to the pesticide. One of these involved a 12-month-old child who ingested an unknown amount of malathion, used for spraying on his parents' farm. The amount of pesticide used in farm sprays is as high as 50 per cent or more, and it would be a hazard to anyone ingesting these substances.

In general, plants ingested were either in subtoxic amounts or non-toxic. Therefore, the usual procedure for these cases was treatment which was easily implemented at home.

The "miscellaneous" category contained substances whose frequency did not warrant a specific category. Among these were various kinds of cosmetics, foods, chemicals, industrial products and animal bites. These last were three copperhead bites, all of which warranted intensive emergency and follow-up measures.

Although the Center has received an increased number of calls during 1972, it is important to note that the Center is fully aware that it is not reaching the total community and many ingestions and poisonings are not known by it or any other medical personnel. It can only be assumed that the most serious of these are reaching some facility for treatment.

Reviewing the deaths for both the counties in Maryland and Baltimore City, certain factors become evident (see Tables on pp. 20-21):

1. As mentioned before, medicines and/or drugs are found frequently as a cause of death. The median age for deaths from drugs (excluding narcotics) in the counties was 45 years and in the city was 40 years.
2. Barbiturates were frequently a cause of death in the counties with a high percentage of these being suicides (88 per cent). This same factor was not evident in the city.
3. Narcotics and narcotism cause a large number of deaths in both the counties (12 per cent of total deaths) and Baltimore City (61 per cent). The median age was 21.5 for the counties and 22 years for the city.
4. In the counties, 39 per cent of the total deaths was caused by carbon monoxide (CO), from

either motor vehicles (31 per cent) or other sources. Eleven per cent of these were either suspected or verified to be suicides. (This same factor was not evident in the city). The median age for death from CO was 38 years.

5. Of the seven children (ages 0 to 13) in Maryland who died, the following are known to have received medical attention: four medicine deaths (0 to 4 years), one glue sniffing (12 years), and one petroleum distillate. The child who died from lead encephopathy may not have received medical attention.
6. The city death statistics note alcohol as being an additional substance found in four deaths but do not indicate any deaths from this alone. The counties note only one death from alcohol, and there is no note of multiple substances in any death.

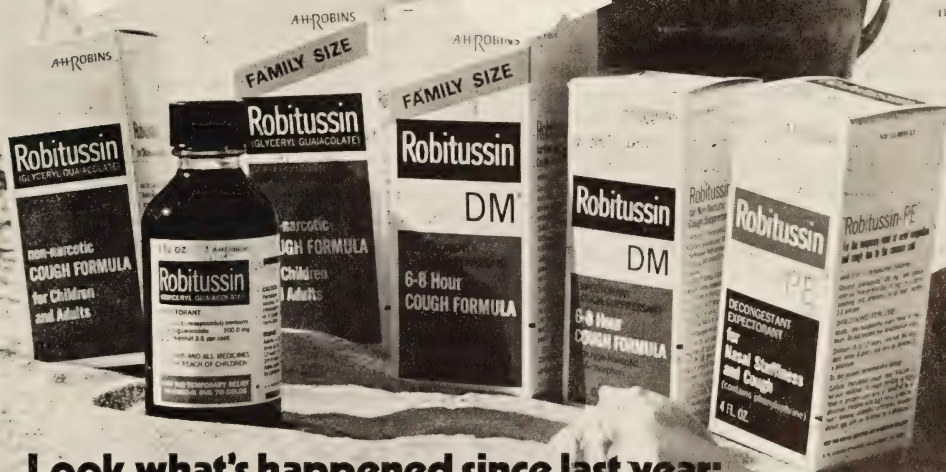
Some conclusions can be drawn:

1. Suicides with drugs have been known to be increasing not only in this area but throughout the country. With increased awareness of the high lethality potential of barbiturates, it is hoped that physicians will decrease the use of these, especially in individuals who are prone to having emotional problems.
2. Since "narcotism" does not necessarily mean that the individual died from narcotics, it is very possible that these individuals died from secondary factors or even other drugs. Many individuals working in the field of drug addiction feel that this kind of behavior is of "self-destructive" nature and has a high order of lethality. The MPIC has many callers who are drug abusers and addicts and who have verbalized their wish to kill themselves by overdose or other methods. This is particularly frequent when the individual faces a conflict such as incarceration, rejection by family, etc., with which he cannot adequately cope.
3. As in previous years, the carbon monoxide deaths continue to show a high frequency of lethality in the counties. It would be important to review the histories of these cases and other findings to determine mechanisms for identification of those factors which permit such deaths. In this manner, prevention may be possible. One can only assume that such factors exist, since the difference in the number of CO deaths in the counties and Baltimore City is striking.
4. What information is available on the children who died from drugs indicates that with better dissemination of information further such deaths can be prevented. The number of deaths from lead encephopathy has decreased, but further screening and treatment must increase in order to prevent any mortality or morbidity from plumbism.

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Sales of the three Robitussins have leaped forward from a 9.6% share of the market in 1969 to a 12.9% share in 1972. Your Robins Representative will be around soon with the facts on this big, money-saving deal. Buy 'em while it's hot for more cold profit all during the 1973-74 cough-cold season.

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Since the Center wishes to look at the effectiveness of its program, it was necessary to determine the frequency of ingestions in the community. As has been noted by many authors in other areas of the country, many ingestions and poisonings never come to the attention of the medical professionals; it is impossible to know the frequency of such cases. In anticipation of a full-scale survey, the MPIC undertook to examine the frequency of poison calls made to the Center from various geographic areas. It was suspected that a large, unmet need for information was present in the inner city. Having evaluated the reports for a six-month period, several factors became evident:

1. The majority of calls come from within the area bounded by Cockeysville and Parkton; Belair and Joppa; Essex and Dundalk; Annapolis; Arbutus, Catonsville and Columbia. This in general has been defined by others as the "Baltimore Metropolitan Area."
2. The city as a whole had far fewer calls to the Center than either Baltimore County or Anne Arundel County.
3. Separating the city into areas (on the basis of census tracts and population so that each final area identified would be similar in numbers of children under five), it has been seen that frequencies of calls to the Center varied from 3.9 to more than 12.8 calls per 1,000 children within the city under five years of age per year.
4. The number of calls received from each area of the city was not necessarily dependent on race, ethnic origin or economic level.
5. In Baltimore County there was a higher frequency of calls (more than two to twelve times as many) for ingestions in children under five years than from anywhere in the city. The frequency approximated 23 ingestions calls for children under five years per 1,000.
6. A similar finding was seen for Anne Arundel County (as far as Annapolis), showing 15 to 20 calls per 1,000 for the same age group.

Based on these preliminary findings, it may be concluded:

1. The Center's reach is limited at least in part due to the lack of a "toll-free" number. The Center will work to correct this within the next year.
2. Although the population in the inner city appears not to be reached by the Center, it is likely that this population, who uses the emergency room for primary care, would continue to do the same for ingestions and poisonings. This may be substantiated by reviewing the emergency room logs and new protocols will be developed during 1973 to look at this factor. The most serious problem appears to be outside the area the Center reaches who have neither poison information centers available nor treatment facilities easily accessible. During 1973 this will be further con-

sidered, and where possible the Center will help in developing methods for better quality of information and care to this population. The preliminary information from this community project will be carried further and there will be data available on variables such as: number of repeaters, types of treatment received and other social variables. It is anticipated that this information will either substantiate or refute what has been said by other authors, such as Sobel, in other areas of the country.

Summary:

Efforts will be made to increase the Center's effectiveness in reaching all areas of Maryland. The Center has begun to meet the need of the community at the "front line," acting in the capacity of evaluator and offering first aid measures that can be used in the home. Thereby, the Center has helped in diminishing the unnecessary overload in the emergency room. Throughout the coming year, the Center will make a greater endeavor to broaden this effort.

Further efforts will be made to bring to the attention of community physicians, the need to evaluate their patient's emotional status before prescribing barbiturates and other such sedatives as adjunct to their therapy. Emphasis must also be made to point out the need for physicians to support the efforts of the pharmacist in using safety closure caps and other safety packaging.

In addition, the MPIC will be developing training packages in conjunction with emergency treatment facilities to help increase their personnel's expertise in the treatment of poisonings. The Center anticipates, with close communication with these emergency rooms, research may develop that will allow evaluation of existing treatment modalities and development of new techniques.

The Center will attempt through increased knowledge factors in the deaths within the state from poisoning to help in curbing and eliminating many of these kinds of deaths.

The community pilot study will be broadened and further significant variables will be considered in the frequency and kinds of poisonings within the state.

Mary S. Furth, M.D., M.P.H.
Director
Maryland Poison Information Center

TABLE I

THE 1972 statistics for per cent of ingestions in each age group in each specific category. (THE 1971 statistics for the same groups.)

TRANQUILIZERS AND BARBITURATES:

1-4	5-11	12-24	25 and over
22.4%	4.3%	42.3%	25.9%
(37.1%)	(0.5%)	(25.9%)	(24.4%)

OTHER INTERNAL MEDICINES:

1-4	5-11	12-24	25 and over
72.9%	5.9%	11.9%	5.2%
(74.2%)	(5.1%)	(10.3%)	(4.8%)

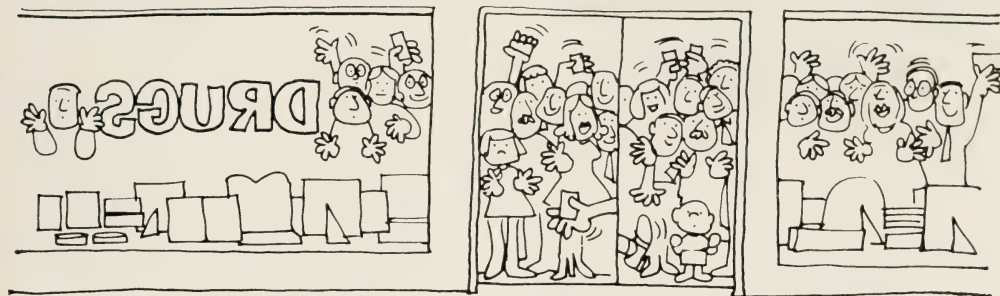
(Continued on Page 20)

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That means many people will be hearing about the reliable pain relief of Empirin Compound for the first time. And many of them will be coming to you with the 25¢-off coupon we put in every ad. (Of course, we're telling them Empirin Compound is available at their pharmacy.)

So stock up on Empirin Compound before the deluge. We have a hunch you'll be glad you did.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

(Continued from Page 18)

EXTERNAL MEDICINES:

1-4	5-11	12-24	25 and over
89.6%	1.9%	2.9%	4.3%
(83.6%)	(4.3%)	(1.9%)	(5.0%)

HOUSEHOLD PRODUCTS, PETROLEUM DISTILLATES & PESTICIDES:

1-4	5-11	12-24	25 and over
83.4%	4.0%	3.4%	5.9%
(82.5%)	(3.2%)	(1.9%)	(4.4%)

OMITTED FROM THE ABOVE TABLES ARE THE STATISTICS FOR THE AGE UNKNOWN GROUP.

TABLE II

SUMMARY OF POISON CONTROL CENTERS FROM 1966-1972

Year	Total of Calls (all centers)	Maryland Poison Information	1-4	5-11	12-24	25+
1972	6,866 Ingestions (9,382 Calls)	5,707 (8,223)	.75	.05	.09	.07
1970	6,054	3,365	.55	.03	.21	.21
1968	5,141	2,408	.53	.05	.19	.23
1966	3,681	1,531	.70	.04	.05	.21

Total number of ingestions for State, and those for Maryland Poison Information Center per every 2 years since the first full year. Included are proportions of ingestions for each age group from the Maryland Poison Information Center.

MARYLAND POISON INFORMATION CENTER
YEARLY TOTAL FOR 1972

Substance	Age Un- known	Less Than 1	1-4	5-11	12-24	25 Over	Total
Aspirin	3	2	277	8	55	19	364
Tranquilizers							
Barbiturates	24	2	107	21	205	126	485
Other Internal Medicines	19	6	933	72	148	59	1237
External Medicines	6	24	381	8	13	23	455
Household Products	22	57	870	41	27	36	1061
Petroleum Distillates	9	12	301	6	23	36	387
Pesticides	9	20	166	21	8	13	237
Plants	4	42	234	20	6	6	312
Miscellaneous	25	70	826	82	73	93	1169
Total	121	235	4095	279	558	419	5707

MARYLAND POISON INFORMATION CENTER

YEARLY 1972

	Age Un- known	Less Than 1	1-4	5-11	12-24	25 Over	Total
Number Repeaters		1	79	2	3		85
Attempted Suicide	8			1	121	92	222
Intent Unknown	6			15	93	56	170
Drug Abuse							
Treated		Medical Call 851				Non-Medical Call 4856	
Deaths							

No. of ingestion	5707	No. of Pesticides	237
No. of inquiries	2516	No. of Hydrocarbon	387
No. of drug abuse	205	Pts. Hospitalized	95

Deaths 1972 — Counties of Maryland

There were 153 recorded poisoning deaths in the counties of Maryland.

- 26 Accidental
- 18 Narcotism or Dependency
- 96 Suicide
- 13 Equivocal, Intent Unknown

Substance	Incidence
Alcohol	1
Gas—Motor Vehicle (Carbon Monoxide)	46
Other Carbon Monoxide	14
Other Gases	2
Barbituates	27
Psychotropic	4
Salicylates	3
Narcotics	7
Narcotism	14
Heavy Metals	1
Petroleum Products	1
Insulin	1
Other Drugs	15
Other Chemicals	15

There were 2 deaths in children under 2 years of age.

- 1½ year old—lead
- 1½ year old—antifungal agent

POISON CONTROL CENTERS — 1972 REPORTS

STATE OF MARYLAND

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Total
Maryland Poison Information	291	349	485	395	438	469	465	484	506	586	645	562	5675*
Johns Hopkins Hospital	45	39	22	18	22	42	40	102	31	97	37	39	534
Suburban Hospital	51	46	66	61	42	53	50	56	46	56	52	46	625
	387	434	573	474	502	564	555	642	583	739	734	647	6866

Total Number of Calls into Maryland Poison Information Center for 1972—8223

*Corrected Total = 5707

Narcotics: Deaths range from 15.5 years to 42.5 years (Median = 21.5 years)

Gases: Deaths range from 17.5 years to 78.5 years. (Median = 38 years).

29% Accidental

66% Suicidal Intent

5% Equivocal, Intent Unknown

Drugs (excluding Narcotics): Deaths range from 1.5 years to 86 years (Median age = 45 years).

4.6% Accidental

7.7% Equivocal, Intent Unknown

87.7% Suicide

Deaths 1972 — Baltimore City

There were 102 recorded poisoning deaths in the city of Baltimore.

12 Accidental

61 Narcotism or Dependency

28 Suicides

1 Equivocal, Intent Unknown

<i>Substance</i>	<i>Incidence</i>
Alcohol (found at least with 4 other cases of death, but not found singly)	
Gases: Motor Vehicle (Carbon Monoxide)	1
Other Carbon Monoxide	5
Barbituates	6
Psychotropic	3
Salicylates	5
Narcotics	1
Narcotism	61
Petroleum Products	2
Drug Reaction (Penicillin)	1
Anesthetics	3
Bleach	1
Other Drugs	12
Other Chemicals	1

There were 4 deaths in children 2 years old and under.

1 year old—Salicylate

1 year old—Petroleum Distillate

1 year old—Cytosan

2 year old—Tofranil

There was also an adolescent death in the city.

13 year old—Hydrocarbon abuse

Narcotics: Deaths range from 16 years to 74 years. (Median = 22 years) 90% of all deaths occurred in the age group between 16 years and 29 years.

Drugs (excluding Narcotics): Deaths range from 1 year to 75 years. 94.5% of all deaths occurred between 21 years and 75 years.



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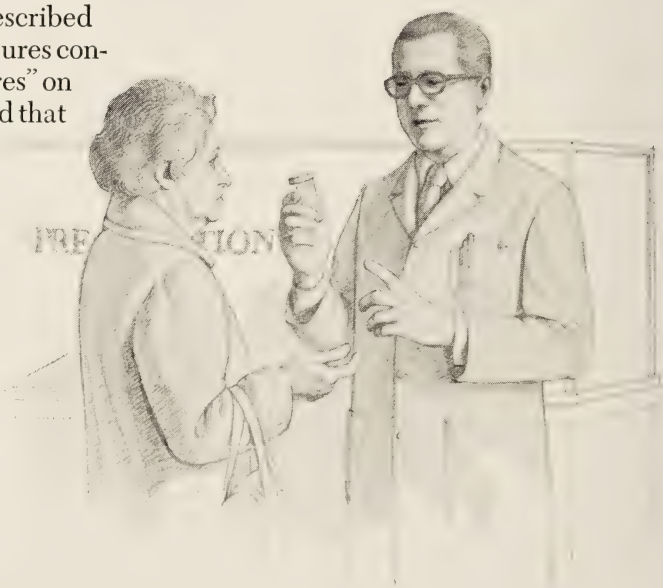
Wide clinical experience has shown that, in properly selected patients, levodopa is the most effective agent for relief of symptoms of Parkinson's disease and syndrome, and that Larodopa (levodopa) is the brand of levodopa most widely preferred by physicians. Only Larodopa is available in tablet as well as capsule form. Its wide range of dosage options permits you to meet the varying requirements of most levodopa prescriptions without a large inventory of different brands.

As the most frequently prescribed brand of levodopa, Larodopa assures constant turnover and seldom "expires" on the shelf. Physicians are informed that Roche has the widest pharmacy distribution of all levodopa products and, as leader in the market, has a continuing commitment to levodopa promotion and research.

Larodopa offers consistently high quality—and only Larodopa provides the Roche-patented tablet form of levodopa. The scored, easily divided tablet makes it possible to use a single-strength tablet to vary

the dose as needed. This is both more convenient and less confusing for the patient, as it eliminates the need for multiple prescriptions for capsules of differing strengths.

Consistent with pharmacy-oriented policies, Roche maintains equitable and competitive pricing, assures a liberal "returned goods" credit and does not distribute unsolicited samples of Larodopa (levodopa).





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levodopa/Roche®**

Tablets, conveniently scored for maximum flexibility, 0.1 Gm, 0.25 Gm, 0.5 Gm
Capsules also available, 0.25 Gm, 0.5 Gm

Before prescribing, please consult complete product information, a summary of which follows:

In order to reduce the high incidence of adverse reactions, it is necessary to individualize the therapy and to gradually increase the dosage to the desired therapeutic level.

Indications: For the treatment of idiopathic Parkinson's disease (paralysis agitans), postencephalitic parkinsonism, manganese intoxication, symptomatic parkinsonism due to carbon monoxide intoxication, and parkinsonism in the elderly associated with cerebral arteriosclerosis.

Contraindications: In patients receiving MAO inhibitors (the latter must be discontinued two weeks prior to initiating therapy with Larodopa); in narrow angle glaucoma; and in patients with known hypersensitivity to levodopa.

Warnings: Administer cautiously to patients with severe cardiovascular or pulmonary disease, bronchial asthma, renal, hepatic or endocrine disease. Administer with care and in a facility with a coronary care unit or intensive care unit to patients with myocardial infarction who have residual atrial, nodal or ventricular arrhythmias. Be alert to possibility of upper gastrointestinal hemorrhage in patients with a history of active peptic ulcer disease. Monitor carefully all patients for development of depression with concomitant suicidal tendencies. Treat psychotic patients with caution.

Oral doses of 10 to 25 mg of pyridoxine hydrochloride (vitamin B₆) rapidly reverse the toxic and therapeutic effects of Larodopa (levodopa). Therefore, carefully consider concomitant administration of the two agents. In pregnancy, weigh potential benefits against possible hazards. Do not use in nursing mothers. Safety of Larodopa in children under age 12 not established.

Precautions: Periodic evaluations of hepatic, hematopoietic, cardiovascular and renal function recommended during extended therapy in all patients. Patients with chronic wide angle glaucoma may be treated cautiously provided intraocular pressure is well controlled and monitored carefully during therapy. To patients on an antihypertensive drug, administer carefully, adjusting dosage if necessary. For patients receiving pargyline, see note on MAO inhibitors contraindications.

Adverse Reactions: *Most serious*—occurring most frequently: adventitious movements (e.g., choreiform and/or dystonic); *most serious*—occurring less frequently: cardiac irregularities and/or palpitations, orthostatic hypotensive episodes, brady-

kinetic episodes (the "on-off" phenomena), mental changes including paranoid ideation and psychotic episodes, depression with or without the development of suicidal tendencies, dementia, and urinary retention; *most serious*—occurring rarely: gastrointestinal bleeding, development of duodenal ulcer, hypertension, phlebitis, hemolytic anemia, agranulocytosis, and convulsions. (The causal relationship between convulsions and Larodopa has not been established.)

Less serious—occurring relatively frequently: anorexia, nausea and vomiting with or without abdominal pain and distress, dry mouth, dysphagia, sialorrhea, ataxia, increased hand tremor, headache, dizziness, numbness, weakness and faintness, bruxism, confusion, insomnia, nightmares, hallucinations and delusions, agitation and anxiety, malaise, fatigue and euphoria; *less serious*—occurring less frequently: muscle twitching and blepharospasm (which may be taken as an early sign of over-dosage; consideration of dosage reduction may be made at this time), trismus, burning sensation of the tongue, bitter taste, diarrhea, constipation, flatulence, flushing, skin rash, increased sweating, bizarre breathing patterns, urinary incontinence, diplopia, blurred vision, dilated pupils, hot flashes, weight gain or loss, dark sweat and/or urine; *less serious*—occurring rarely: oculogyric crises, sense of stimulation, hiccups, development of edema, loss of hair, hoarseness, priapism and activation of latent Horner's syndrome.

The following have been noted: elevations of BUN, SGOT, SGPT, LDH, bilirubin, alkaline phosphatase or PBI; occasionally, reductions in WBC, hemoglobin and hematocrit; elevations of uric acid with use of colorimetric method but not with uricase; occasionally, positive Coombs test; leukopenia, requiring at least temporary discontinuance of Larodopa (levodopa).

Dosage and Administration: Because of the necessity for individualizing therapy, the usual optimal therapeutic dosage should not exceed 8 Gm, and should be carefully titrated for each individual patient. The physician should thoroughly familiarize himself with the information in the package insert before instituting therapy.

How Supplied: *Tablets*, pink, scored, containing 0.1 Gm levodopa (imprinted ROCHE 72), bottles of 100; containing 0.25 Gm levodopa (imprinted ROCHE 57) or 0.5 Gm levodopa (imprinted ROCHE 56)—bottles of 100 and 500.

Capsules, containing 0.25 Gm levodopa (pink and beige, imprinted ROCHE 55) or 0.5 Gm levodopa (pink, imprinted ROCHE 54)—bottles of 100 and 500.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

University of Maryland School of Pharmacy

Senior Convocation

The senior convocation for graduating pharmacists of the University of Maryland School of Pharmacy was held Thursday, May 31.

Guest speaker at the event was Dr. Edward J. Kowalewski, professor and head of the family practice program at the University of Maryland School of Medicine.

Outstanding students were recognized and the awards presented. The student recipients were: *Gold Medal for General Excellence*, Martin Isaac Herman, Reisterstown; *Certificates of Honor* to holders of next highest averages, Miles Stephen Blumberg, Baltimore; Donald Sender Bialek, Lanham; Michael John Evanko, Jr., Baltimore; *L. S. Williams Practical Pharmacy Prize*, to the senior student having the highest general average throughout the course in practical and dispensing pharmacy: Kenneth William Meagher, Baltimore; *Andrew G. DuMez Medal*, for superior proficiency in pharmacy, James David Babb, Baltimore; *Conrad L. Wich Pharmacognosy Prize*, for exceptional work throughout the course in pharmacognosy, Michael John Evanko, Jr., Baltimore; *William Simon Memorial Prize*, for superior work in the field of practical and analytical chemistry, Donald Sender Bialek, Lanham; *Wagner Pharmaceutical Jurisprudence Prize*, for meritorious academic achievement in pharmaceutical jurisprudence, Martin Isaac Herman, Reisterstown; *John F. Wannenwetsch Memorial Prize*, to a senior student majoring in general pharmacy who has exhibited exceptional performance and promise in the practice of community pharmacy, Joseph Matthew Ras, Edgewood; *David Fink Memorial Prize*, to a senior student for proficiency in the general practice of pharmacy, Gordon Alexander Ireland, Laurel; *Kappa Chapter, Alpha Zeta Omega Fraternity Prize*, to a senior student for proficiency in pharmacy administration, Charles Richard Downs, Clear Spring; *Maryland Society of Hospital Pharmacists Award* to a senior student who shows promise in the area of hospital pharmacy, Linda Walter Bosco, Laurel. Also announced at the senior convocation were those students eligible for honors and high honors at the 1973 Commencement. They are: *High Honors*, Donald Sender Bialek, Lanham; Miles Stephen Blumberg, Baltimore; Michael John Evanko, Jr., Baltimore; Martin Isaac Herman, Reisterstown; David Allan Lewis, York, Pa. *Honors*, Gordon Alexander Ireland, Laurel; Arnold Eugene Clayman, Randallstown; Charles Richard Downs, Clear Spring; Ellen Hersberger Yankeelow, Baltimore; Stephen Gregory Lewis, York, Pa.; Charles Edward Leary, Freeland.

This years new members of Rho Chi, national honorary pharmaceutical society, are: Fifth Year Students: Arnold Eugene Clayman, Charles Richard Downs, Charles Edward Leary, David Allen Lewis, Frances Greenberg Statter; Fourth Year Students: John Fred-

erick Bender, Robert Ray Foreman, Russel Alan Gobeille Harold Douglas Harrison, Barry Lynn Keeler, Nickola Louise Kuhn, Sherry Raye Norwitz, Bonnie Lee Pitt, Joseph Lawrence Pollard, Carroll Guy Rusk, Jr., Larry Keith Westfall; Graduate Students: Tariq Arthur Andrea, Carroll Dwight Arnett, David Maitland Arrington, Stephen Lester Hilbert, James Wesley King, David Sheldon Roffman, James Kenneth Walters, Jr.

Scientists Study Crib Deaths in Washington

Results of a 44-month study of all sudden infant death syndrome (SIDS) cases occurring in King County, Washington, point to viral infections as playing a leading contributory role. This and similar recent epidemiological studies are providing a base upon which scientists may be able to build a theory to explain the causes of SIDS.

Out of 73,315 infants born during the study period, 170, or one in every 432 live births, died of SIDS.

University of Washington investigators, partially supported by the National Institute of Child Health and Human Development (NICHD), found seasonal clustering of SIDS and suggested this indicated that the syndrome has epidemic-like characteristics, and may implicate viral infections.

Other evidence included an increased incidence among male infants. Scientists found increased occurrence in low social class and in nonwhite families, among whom infections are believed to spread faster because of crowded living conditions. Moreover, 44 percent of SIDS babies had "colds" during the two-week period prior to death.

Abraham S. Bergman, M.D., and his associates believe that viruses probably act more as a "triggering agent" than as a cause.

Acupuncture Grant

A three-year grant to the Missouri Institute of Psychiatry in St. Louis from the National Institute of General Medical Sciences begins Federal funding of research to assess the pain relieving capabilities of acupuncture. Physicians at the St. Louis facility, an affiliate of the University of Missouri School of Medicine, will compare the analgesic qualities of acupuncture anesthesia with those of standard pain-relieving drugs as well as hypno-anesthesia. Two groups of volunteers — a group suffering chronic and continuing pain, and a control group—have been recruited for the project. A major purpose of the project is to develop a better understanding of how the brain functions, particularly in response to anesthesia and pain as well as to learn more about acupuncture.

Prince Georges Montgomery County Pharmaceutical Association

Officers installed at the May 6 Installation Dinner of the Prince Georges-Montgomery County Pharmaceutical Association were as follows:

President	S. Ben Friedman
First Vice President	Henry Theis, Jr.
Second Vice President	M. Neal Jacobs
Third Vice President	Edward S. Sandel
Fourth Vice President	Leonard Rosenberg
Secretary	Paul Reznick
Associate Secretary	Edward D. Nussbaum
Treasurer	Stanley L. Rosen

Executive Committee

Edward D. Nussbaum, Chairman

Michael Leonard

Robert Irby	Joe Rose
Lawrence F. Gusman	John McKirgan
Ralph Arline	Oliver Tibbs
Simon Zvares	Norman Stein

Ex-Officio

Ben S. Mulitz	Paul Gallagher
Henry Johnson	Herman Bloom

General meetings of the Prince Georges-Montgomery County Pharmaceutical Association have been scheduled for the 1973-1974 year. The meetings will be held on Wednesdays at 10 p.m. at the Old Bimar Pharmacy Hall, 9423 Georgia Avenue, Silver Spring, Maryland (3 blocks South of Beltway).

The first meeting on Wednesday, September 5 included general business and committee reports and Mr. George Freedman, Pharmacy Consultant, USPHS, spoke on "Community Pharmacy and Nursing Homes and Related Institutions."

Other meetings are scheduled as follows:

October 24, 1973—Lt. Kennedy-Armed Robbery and You

November 18, 1973—Annual Scholarship Dinner/Theater

January 16, 1974—Rap Session—Pending State legislation before Maryland General Assembly

February 20, 1974—Continuing Education Program

The 19th Annual Scholarship Affair will be held on Sunday, November 18 at 7:00 p.m. at the Harlequin Dinner Theater. Tentatively scheduled is a comedy entitled "Little Me." For reservation information please contact Henry Theis in Rockville at 942-5536.

A.Z.O. News

New officers for 1973-1974 were installed at the Installation Banquet of Kappa Chapter, Alpha Zeta Omega Fraternity held at the Hunt Valley Inn on June 24, 1973.



Photo by Paramount Photo Service

Officers 1973-1974 A.Z.O. Pharmaceutical Fraternity (l. to r.): Dennis Klein, Exchequer; Mark Levi, Recording Signare; Alan Stoff, Sub-Directorium; Jerry Cohen, Directorium; Arnold J. Honkofsky, Corresponding Signare; Leslie Benson, Undergraduate Sub-Directorium and Arnold Caplan, Bellarum.

The 1973-1974 schedule for Kappa Chapter of Alpha Zeta Omega Pharmaceutical Fraternity began with the Annual AZO Crab Feast on August 12. The crab feast was held at the fraternity house. Tentative plans for the coming year are as follows:

August 29—Induction of new members
September 16—Breakfast Meeting
October—Wine and Cheese Party
November—Party
December 31—New Year's Eve Party
February—Night of Games
March—Joint Dinner
April—Bolton Hill Dinner Party
May—Surprise

Allegany-Garrett County Pharmaceutical Association

The new officers for the 1973-1974 term of the Allegany-Garrett County Pharmaceutical Association are as follows:

President	E. Guy Dowling
Vice President	John Balch
Secretary-Treasurer	Linda McMichael
House of Delgates	Ernest Gregg
	C. Murray Allen, E. Dowling

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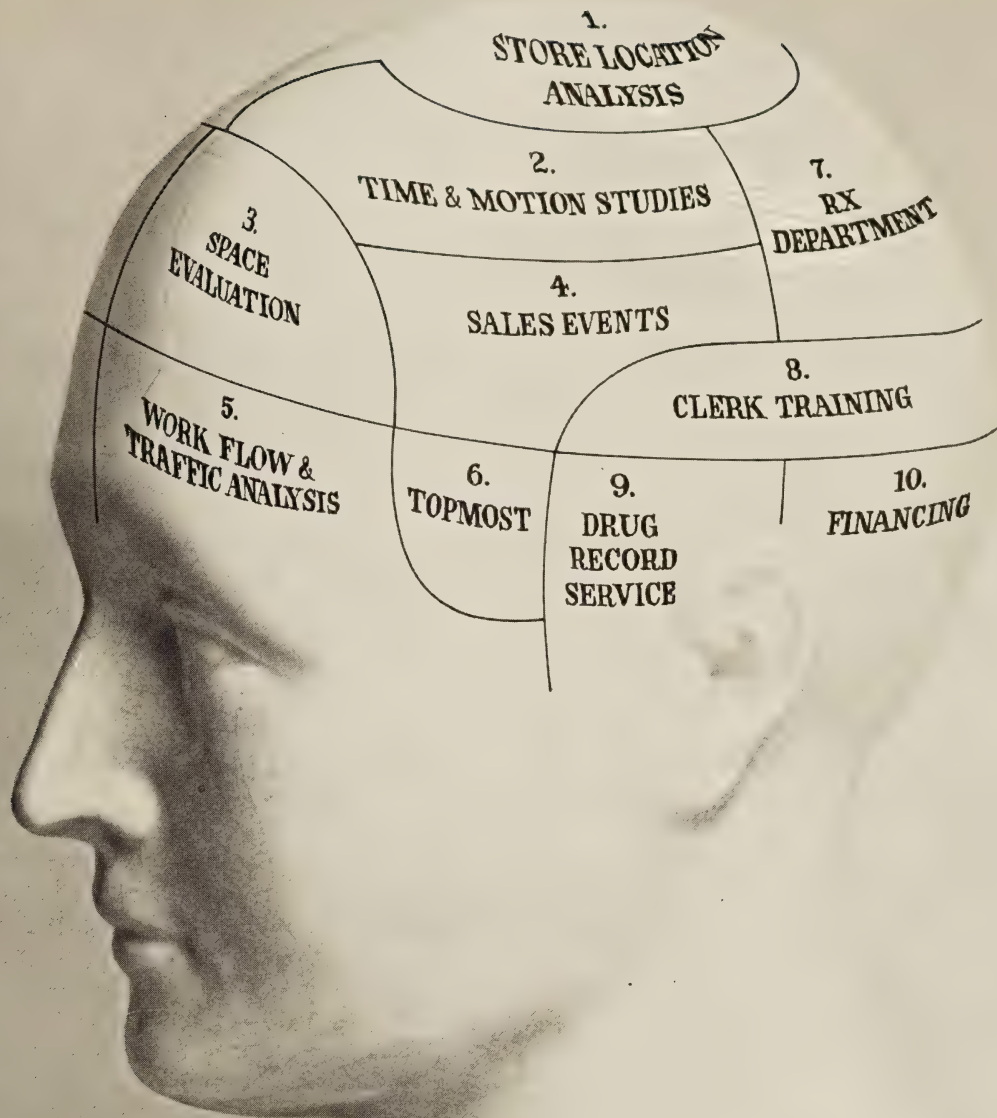
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| 8. Do you hold clerk training meetings on a regular basis?..... | <input type="checkbox"/> | <input type="checkbox"/> |
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| 10. Does your budget provide for store modernization?..... | <input type="checkbox"/> | <input type="checkbox"/> |

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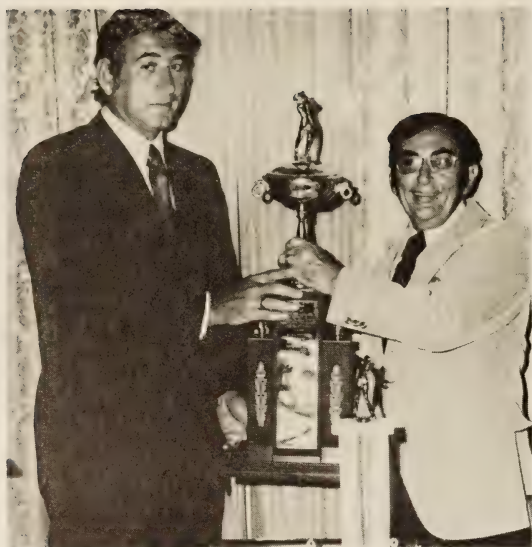
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Herman Bloom of Paramount Photo (right) receives first prize trophy from Leonard Rodman, 1972 winner, at District of Columbia Pharmaceutical Association Annual Convention at Bedford Springs, Pennsylvania.

Eli Lilly Forms New Division

Eli Lilly and Company announced the formation of a new component to be known as the Pharmaceutical Division. The primary responsibility of the new division will be pharmaceutical marketing in the United States. Secondly, the new division and Eli Lilly International Corporation will give joint attention to establishing new methods of coordinated pharmaceutical marketing planning on a world-wide basis.

Eugene L. Step will become President of the new division. William R. Hutchinson, a 1938 graduate of Loyola University School of Pharmacy, will become Executive Vice President of the new division and Edward R. Roberts will become Vice President in charge of Marketing Development and Planning for the new division. Mr. Roberts, a registered pharmacist in the United Kingdom and Canada, received a Pharmaceutical Chemist degree from Leicester School of Pharmacy, Leicester, England, in 1951.

Support Your Associations

"In Unity There Is Strength"

Holiday In Israel

A ten day "Holiday in Israel" with optional 4 night extension tour to Rome will be sponsored by the Maryland Pharmaceutical Association February 18-28, 1974.

The trip spotlights include:

- ★ Round trip jet via El Al Israel Airlines.
- ★ Nine nights in deluxe Plaza Hotel in Tel Aviv and superior first class Shalom Hotel in Jerusalem.
- ★ Evening at a night club in Israel with drink.
- ★ Israeli folklore evening.
- ★ Visit to the pharmacy school of Hebrew University.
- ★ Special meetings and seminars with Israeli pharmacists. Visit to a pharmacy in Old Jerusalem.
- ★ Unique one day air/bus tour to the Galilee.
- ★ Memorable tree planting ceremony in Jerusalem.
- ★ Boat ride on Lake Kinneret (Sea of Galilee).
- ★ Sabbath at the Wailing Wall.
- ★ Exciting optional 4 night extension tour to Rome.
- ★ Dine around program in Rome.
- ★ Four night extension in Israel available.

The all inclusive price (per person, double occupancy) is \$657.00 plus 7% tax and service. Single supplement \$65.00. Two 4-night extension tours are optional. A four night extension tour to Rome is available at \$205.00 per person added to basic tour price, and a 4-night extension tour to Israel is available at \$145.00 per person added to basic tour price. For further information contact the MPhA office at 727-0746 or Nathan Schwartz at 269-0212.

CHANGE OF ADDRESS

When you move—

Please inform this office four weeks in advance to avoid undelivered issues.

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Thank you for your cooperation.

Nathan I. Gruz, Editor
Maryland Pharmacist
650 West Lombard Street

The only thing worse than being ill, is being bored

The cold and flu weather is on its way.

And most people can put up with the sneezing and coughing.

But finding something to do during all those hours in bed, that's a real pain.

A person can only stand those game shows and soap operas for so long, before all they want to do is lay back with something good to read.

Maybe a sports magazine, a hobby book, a paperback novel or a news magazine.

What medicine does for their body, reading does for their mind.

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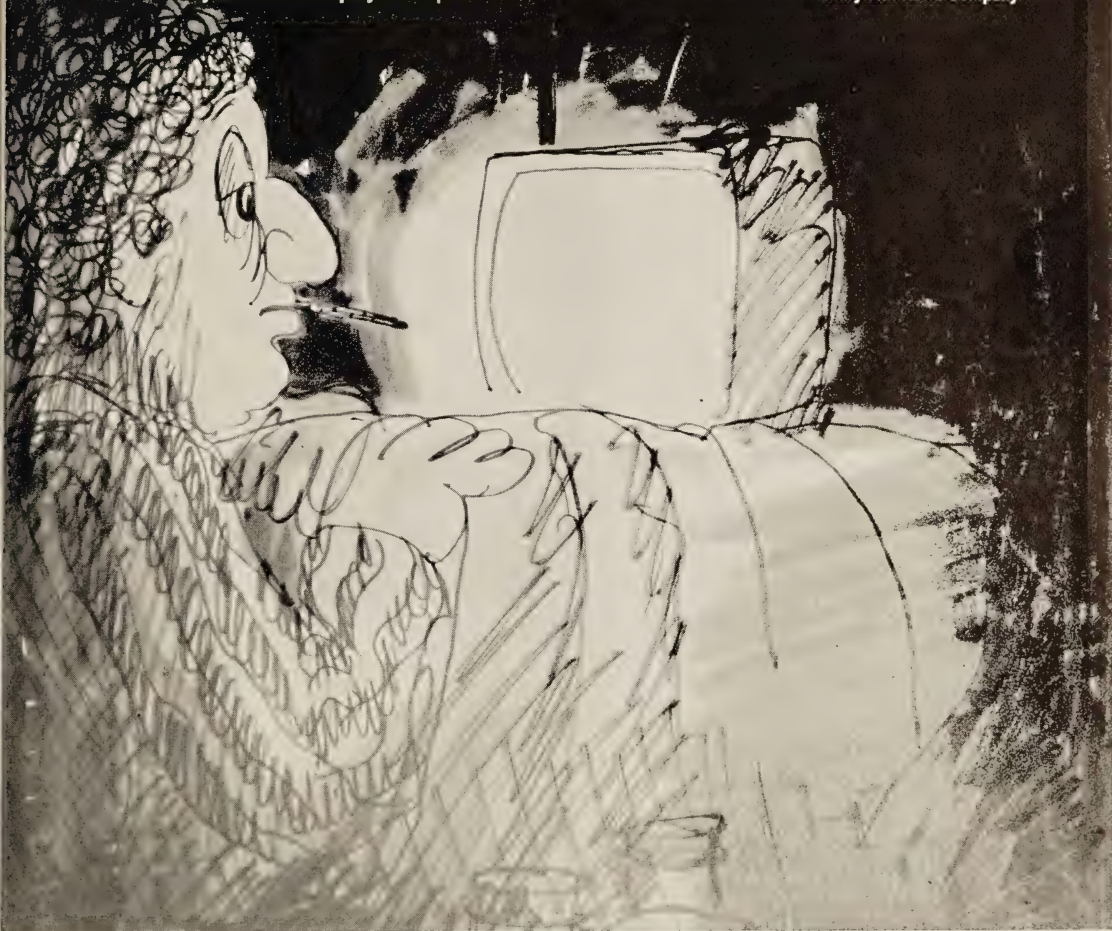
The mathematics are quite simply: for an initial outlay of \$100 you can expect a return of \$127 within thirty days. And any unsold copies are returnable for full credit.

And when you have the very best reading material on sale in your pharmacy, people develop a habit of coming back.

So give us a call at 233-4545.

Maybe we're just what the doctor ordered.

Maryland News Company



Every time a patient brings you an Rx or asks to recommend an OTC medication—that's an opportunity for you to help keep variables from interfering with drug therapy.

For example, a patient hands you an Rx, the therapist is in one week from as many physicians. At that moment, you are in an ideal situation to evaluate certain variables which may or may not interfere with therapy. Is there a possibility of drug incompatibility? Diminished therapeutic effects? Contraindications? You are in a unique position with specialized knowledge to exercise your professional last control, whatever the therapy.

And today, your professional expertise is in greater demand than ever... as knowledge accumulates about the complexities of multiple drug treatment... as more sophisticated products appear... as more patients self-medicate... all increasing the need to exert extra vigilance for the best possible health care.

Let's take a closer look at the many variables that can keep from interfering with drug therapy.

***As the last
professional seen
by the patient,
you can keep variables
from interfering with drug therapy.***



You

The variable of multiple physician prescribing.

Many patients see more than one physician. For example, in a recent study of 75 patients, 33 received Rx's from two or more physicians and used multiple medications in a 30-day period! "Surprisingly, the tendency to obtain prescriptions at different pharmacies was not as prevalent as had been expected."¹ The majority of patients, fifty-two (86.7%), obtained them from one pharmacy; and only eight (13.3%), from two pharmacies¹—such a situation presents an ideal opportunity for you to compile an accurate prescription profile that permits double-checking to rule out drug antagonism or contraindication. That's keeping a variable from interfering with therapy. That's the last control.

The variable of self-medicating.

While Americans utilize many OTC drugs, a great many patients make no mention of them to their physicians. Further, a patient may use several different OTC's, sometimes in combination with one or more Rx products. You can put it all together into a medication profile from which you can guide the patient to safer usage. That's keeping a variable from interfering with therapy. That's the last control.

The variable of multiple drug dispensing.

You have the opportunity to prevent adverse drug effects. Hospital admissions due to drug intolerance or overdose or from interaction of two or more chemically or physiologically incompatible drugs have been reported.² You can play a pivotal role in prevention. You can be the right person, at the right place, at the right time. You can ascertain correctly from the patient's medication record whether an undesirable drug interaction is likely. That's the last control.

The variable of eating and drinking.

Suppose a patient hands you an Rx for an MAO inhibitor. An inquiry about the physician's instructions plus an extra reminder from you not to drink alcohol or eat tyramine-containing foods like aged cheese could prevent a serious hypertensive crisis. On other occasions some common foods taken with drugs may also produce adverse effects. But with your added advice, eating and drinking need not interfere with therapy. That's the last control.

The variable of drug borrowing.

The use of Rx drugs by the patient's friends and relatives is not uncommon.¹ And, when asked, patients often feel no compunction in disclosing drug borrowing. So when a patron tries to refill someone else's Rx, a simple question may reveal the extent of self-prescribing and self-medicating with borrowed drugs—a course which you can promptly discourage while offering a better alternative. That's the last control.

The important variable: You.

As a health care professional, with expert knowledge of drug interactions, you are in a key position to help minimize the possibility of untoward drug effects.

Unfortunate interactions may occur when a patient ignores or forgets his physician's instructions, when a concomitant OTC purchase is made without the physician's knowledge, or when prescriptions are written by more than one physician, with neither physician made aware of the other's actions. In such situations, *you, as the last control, can minimize the interference of such variables with drug therapy.*

References: 1. Stewart, R. B.: *Hospital Pharmacy* 7:108, April 1972. 2. Krupp, M. A.: *Group Practice* 21:22, Nov. 1972.

The Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



are the last control.

Washington Spotlight For Pharmacists

By

APhA Legal Division

OTC Drug Advertising and The Disclosure of Medical Risk Information

Drug abuse, as we see it, refers to the misuse or over-use of *any* drug, and in that regard advertising of drugs is, indeed, contributing in a significant way to the problem of drug abuse. When drug promotion reaches the point where antacids are offered like martinis, and laxatives are implied as essentials to everyday happiness, then the time has come to take a good hard look at the entire situation.

Richard P. Penna, APhA Assistant Executive Director for Professional Affairs, before the National Commission on Marihuana and Drug Abuse

In recent years, the promotion of over-the-counter drugs has been a subject of increasing concern to both the health professions and the representatives of the public. Congressional committees and private organizations, including the National Council of Churches, have held informational hearings on factors contributing to drug abuse, including the effect of the promotional advertising of OTC drug manufacturers on the public.

Consumers Union, publishers of *Consumer Reports* magazine, has petitioned the Federal Trade Commission to require manufacturers of OTC drugs to disclose certain potential medical risks of their drug products when advertising these products to the public. The petitioner suggests that, when determining the information that must be disclosed, the FTC rely on standards established by the Food and Drug Administration "which has the personnel, expertise and legal authority to require disclosure of medical information on OTC labels, packages and package inserts . . ."

To substantiate the need for such mandatory disclosures in drug product advertising, Consumers Union conducted a survey which compared adverse reactions and side effects now disclosed on the drug label or package insert with the information presented to the public when the product is advertised by television broadcasts. The survey covered 33 widely advertised drug products. Almost all of the drugs surveyed bear on the product label information of medical risks which may result from use of the particular drug. Over half of the drugs surveyed bear on the product label warnings that, in the presence of specific conditions, use of the drug is absolutely contra-indicated. Also, over half of the drug products surveyed bear warnings which require a reduction or discontinuance of the dose in the event of certain conditions or symptoms.

None of the surveyed television commercials indicate any risk associated with the use of the drug products advertised in the commercials. The petitioners conclude that the wholly positive and persuasion oriented presentation of these drug products tends to "water down" the disclosures on the product label to the extent that the consumer may not read the printed information or may not be impressed with the importance of the warnings on the label. According to the petitioner, mandatory disclosure of medical risks when promoting drug products is feasible if the scope of the required disclosure is reasonably limited to the information most vital to the welfare of the consumer.

Frequently, comparable drug products fail to bear even similar warnings on the product label. Therefore, a consumer may well get a distorted appraisal of the possible medical risks of similar products even after reading all the warnings found on each drug product label. Obviously, purchasing decisions will be affected if all medical risks are known to the consumer. The American Pharmaceutical Association encourages every pharmacist to function as an informed, unbiased counselor of drugs and drug products. The Consumers Union petition may or may not provide an impetus for new standards for OTC drug advertising. In any case, pharmacists have an excellent opportunity to enhance pharmacy's professional image and to be of service to their community by instructing their patients in the proper use of over-the-counter drugs.

The Commission on Marihuana and Drug Abuse has recently issued its second annual report. The report examines the roots of the drug problem in the United States and recommends policy directions for both the public and private sectors. The Commission's statements and recommendations to pharmacists and pharmaceutical manufacturers were summarized in a previous Washington Spotlight. The following summarizes the Commission's statements and conclusions on the issues of drug use and drug using behavior which should arouse social concern or merit legal sanctions.

Present Drug Policy

The Commission is convinced that current public policy concerning the drug problem is based on incorrect assumptions, is aimed at wrong targets, and is often unresponsive to human needs. It is behavior that may be

associated with drug use, such as crime, loss of productivity, disruption of the family unit, and economic drain that should form the basis for policy planning.

When the use of a prohibited or socially disapproved drug increases, policy makers traditionally respond by pressing for evermore costly mechanisms of control. Current drug policy can be summed up: increased use of disapproved drugs precipitates more spending, more programs, more arrests, and more penalties, all with little positive effect in reducing use of these drugs.

The Commission feels strongly that the present institutional response, despite sincere efforts to move in the right direction, continues to be rooted in the mistakes of the past. Accordingly, it is useful to consider the goals toward which the policy is directed and the premises which support it.

The Concept of Drug Use

Because alcohol and tobacco are excluded from the public's concept of a drug, the public regards alcoholic beverages and tobacco products as fundamentally different from marihuana, barbiturates, or heroin. Further, the public is conditioned to believe that street drugs act according to entirely different principles than "medical" drugs. The result is that the risks of the former are exaggerated and the risks of the latter are overlooked. This confusion must be dispelled. American drug policy will never be coherent until it is founded on uniform principles which apply to all drugs.

American drug policy has been based on the notion that the ultimate objective is to eliminate the "non-medical" use of drugs. However, no fiction will alter the physiological effects of alcohol and tobacco. Further, the contemporary use of over-the-counter drugs, the advertising of mood-altering drugs, and the backyard pharmacy, where neighbors diagnose their friends' ailments and share their prescription drugs with them, all discount the assumption that drug use can be confined to a medical system.

Risk-Taking and Health

In supporting present social policy, spokesmen often list those drug effects which are potentially harmful to individual health rather than focusing on the social consequences of drug using behavior. The Commission believes that persons taking this approach have misconstrued the nature of the drug issue. The assumption that all psychoactive drug use involves a high risk ignores pharmacological variations among drugs and the importance of frequency of use, method of administration, dose, and non-drug factors as determinants of risk. Further, there is no correlation between the capacity of psychoactive drugs to induce behavioral disorders and their toxicity. Alcohol produces the most clearly established and reproducible brain pathology. Heavy tobacco smoking is associated with greatly increased risk of lung cancer. If the standard for social policy were potential injury to individual health, barbiturates, alcohol, and tobacco would present the clearest cases for prohibition.

Yet, the latter two are available for self-defined purposes and the former is widely used in the practice of medicine.

Social Acceptance

Drug taking in the youth population coincides with social anxieties regarding social disorder in general and youthful behavior specifically. To many, youthful drug use offers a convenient explanation for these problems and marihuana in particular symbolizes the entire spectrum of social concern. Additionally, a deep-seated popular belief that some drugs diminish or destroy the individual's capacity to control his behavior is reflected in hypothesis such as "drugs cause crime" or "drugs cause dropping out" or "drugs cause mental illness." Any perceived correlation between use of the drug and the unwanted consequence is attributed to the drug, removing the individual from any and all responsibility.

Most societies, including our own, have institutionalized at least one form of drug-induced mood alteration; only the drugs differ, not the essential purpose. Instead of assuming that mood alteration through some drugs is inherently objectionable, while similar use of others is not, the public and its leaders must focus directly on the appropriate role of drug-induced mood alteration. It is no longer satisfactory to defend social disapproval of use of a particular drug on the ground that it is a "mind altering drug" or a "means of escape." For so are many "accepted" drugs.

Social Costs and Social Concern

Social concern about the use of a particular drug should correlate with the social costs attending the use of that drug. However, the current social concern bears little relationship to actual social cost. The result has been an overestimation of the nature of the problem attending use of some drugs, such as marihuana, and an underestimation of the problem attending use of other drugs, such as barbiturates and alcohol.

In the context of social cost, the most serious concern in contemporary America should attach to the use of alcohol and heroin. Moderate social concern should attach to the use of amphetamines, barbiturates, hallucinogens, methaqualone, and cocaine, the use of which is relatively well controlled within the present framework. The use of marihuana and the so-called minor tranquilizers appears to require relatively minimum social concern at the present time. Present trends do suggest that the incidence of use of and dependence on barbiturates and cocaine may be increasing and may demand increased social attention.

Varicose veins are widespread throughout the American population and affect almost all ages, reports the National Institutes of Health. They are most common in people over 40, affecting half the women and a quarter of the men beyond that age. With advancing age there is a loss of tone in the skin and tissues that surround and help support veins.

Obituaries

Walter J. Patterson

Walter J. Patterson, 77, co-owner of Irvington Pharmacy since 1926 and a member of the Maryland Pharmaceutical Association and Baltimore Metropolitan Pharmaceutical Association, died on July 29. He was a 1917 graduate of the University of Maryland School of Pharmacy.

Robert O. Wooten

Robert O. Wooten, 78, died unexpectedly after a heart attack on July 20. Mr. Wooten was a 1921 graduate of the University of Maryland School of Pharmacy and had been with the Upjohn Company from 1922 until his retirement in 1959. He was a Past Honorary President of the Alumni Association of the University of Maryland School of Pharmacy and held membership in the Baltimore Veteran Druggists Association and the Travelers Auxiliary of the Maryland Pharmaceutical Association.

Dr. Isidor Allen Sklar

Dr. Isidor Allen Sklar, 67, brother of Judge Albert L. Sklar, died in Phoenix, Arizona on July 18. Dr. Sklar was a 1926 graduate of the University of Maryland School of Pharmacy and obtained his M.D. degree from the Chicago Medical College in 1937.

Dr. Enoch Dickerson

Dr. Enoch Dickerson, 87, former pharmacist at Provident Hospital, died on July 11. He practiced dentistry in Baltimore for 50 years.

Fred J. Schmitt

Fred J. Schmitt, 70, 1929 graduate of the Milton University School of Pharmacy, died on June 27.

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the maryland pharmacist

AUGUST

1973

Volume 49

Number 8

Maryland Pharmaceutical Association Convention Photo Coverage

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The Employee Pharmacist

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by Samuel H. Kalman, R.Ph.

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The Maryland Pharmacist

NATHAN I. GRUZ, *Editor*
NORMAND A. PELISSIER, *Assistant Editor*
ROSS P. CAMPBELL, *News Correspondent*
HERMAN J. BLOOM, *Photographer*

650 WEST LOMBARD STREET
BALTIMORE, MARYLAND 21201
(301) 727-0746

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Editorial . . .

THE EMPLOYEE PHARMACIST

Wanted—registered pharmacist for day, evening, weekend and holiday work, 40-50 hrs. per wk., no lunch, no coffee breaks, no vacation, must answer phone, notarize, make money orders in busy prescription department—few other benefits. Apply in person or call 123-4567.

We wouldn't expect many pharmacists to apply for the above position or even to inquire about the salary. Of course the ad is purposely exaggerated to make a point. What work conditions and benefits should we provide employee pharmacists? This is a difficult question to answer and would depend on the individual situation. In a survey of 30 recent pharmacy graduates living in a six state area, Rogers asked, "Why did you accept the offered pharmacist position?"¹ The order of importance in a series of choices was: 1. Professional atmosphere, 2. Proximity to residence, 3. Salary scale, 4. Fulfill an obligation, 5. Security. It should be noted that there was only a slight difference between the first and third reasons which indicates that the majority of these graduating pharmacists still considered salary scale to be almost as relevant in accepting a position as professional atmosphere. Also, security would be more important to the average employee pharmacist than it might be to a recent graduate.

We know that a tired, overworked person cannot function as accurately and as effectively as he should. What then is the optimal maximum number of prescriptions a pharmacist can fill in a day? Obviously, this will vary from pharmacist to pharmacist. One pharmacist could comfortably fill 150 perhaps while another would have difficulty filling 75 prescriptions. The use of technicians to assist with mechanical functions behind the prescription counter has proven successful. Technicians or helpers can be of tremendous help to the busy pharmacist. That the demand for technicians will increase can be predicted from pharmacy manpower projections. Rodowskas states that at an estimate of 100 prescriptions maximum per pharmacist work day and an average of 250 work days per practitioner, based on our current rate of increase of the number of prescriptions filled there will be 400 million unfilled prescriptions in 1978 if the 100 prescriptions per pharmacist rate holds.²

However, this raises another question. How many technicians can one pharmacist effectively supervise? The answer to this question is presently under study by many including the MPhA and the Maryland Board of Pharmacy. Hopefully there will be effective controls over the use of technicians in Pharmacy. The subject of floating

References

1. Rogers, D., "Relationship Between Selection and Professional Satisfaction," JAPhA, NS12, 176 (1972).
2. Rodowskas, C.A. Jr., "The Pending Crisis in Professional Productivity," JAPhA, NS10, 197 (1970).

pension plans has been discussed with the possibility of coordination through the MPhA or other body.

These topics and related problems are now being tackled by the Employee Pharmacists Committee of the Baltimore Metropolitan Pharmaceutical Association and the BMPA leadership is to be commended for its encouragement and support of this committee. We look forward to a closer relationship between employer and employee pharmacists.

—Normand A. Pelissier

PHARMACY CALENDAR

November 8 (Thursday)—TAMPA Ladies Night, Oregon Ridge Dinner Theater.

November 15 (Thursday)—BMPA Annual Meeting.

November 18 (Sunday)—Prince Georges-Montgomery County Pharmaceutical Association 19th Annual Scholarship Affair, Harlequin Dinner Theater, 7:00 p.m.

December 9-13—American Society of Hospital Pharmacists Midyear Clinical Meeting, New Orleans, Louisiana.

1974

January 27 (Sunday)—Second Annual Alumni Oyster Roast, University of Maryland School of Pharmacy Alumni Association, Overlea Caterers, 6809 Bel Air Rd., 1-6 p.m.

February 3 (Sunday)—Annual Installation Banquet, Baltimore Metropolitan Pharmaceutical Association, Blue Crest North.

February 18-24—Maryland Pharmaceutical Association "Holiday in Israel" with optional extension tour to Rome.

May 29 (Wednesday)—Graduation Banquet, University of Maryland School of Pharmacy, Eudowood Gardens.

June 23-27—92nd Annual Convention, Maryland Pharmaceutical Association, Downingtown Inn, Downingtown, Pa.

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Nathan I. Gruz, Editor
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REPORT OF PRESIDENT, 1972-73

Nathan I. Gruz, Executive Director
Maryland Pharmaceutical Association and Baltimore
Metropolitan Pharmaceutical Association

Presented July 22, 1973, Sheraton-Boston Hotel
Boston, Massachusetts

As long as any of us have been involved in pharmacy we have been concerned with the internal warfare within the profession. The dissension in our ranks and rivalries between various organizations in pharmacy has become an intolerable condition for the pharmacists of the nation.

NCSPAPE over the years has tried to contribute its good offices toward a resolution of this plague, particularly in regard to APhA-NARD relations.

As a result, at the last APhA meeting we adopted a pharmacy unity policy, with "unity in pharmacy as the profession's first priority." A committee was directed to pursue this objective and the expenditures of virtually the entire reserve fund of NCSPAPE was authorized.

I appointed such a committee and personally served as its chairman. We met with the NARD Executive Committee and made our objectives clear. We stressed that the pharmacists of this country were not going to put up with the continuous barrage of invective that was going on between our national organizations. In fact, many pharmacists were saying: "A plague on both your houses!"

Our representatives subsequently went before the APhA Board of Trustees and spoke in the same vein. There were in addition many telephone conversations and personal visits with APhA and NARD leaders.

I stressed to both groups: "Let us put the past behind us, let us start afresh. Let us find the vital issues—let us then work together on those issues upon which we have a common policy."

During recent weeks we have learned of concrete evidence that APhA and NARD officers and executives are working together. We have received jointly sponsored communiques. All of us must salute these efforts and hope the results will be constructive. The formation of COPEP indicates that the national groups can get together on specific areas of common concern and I hope the outcome will be fruitful and permanent.

I believe as leaders of grass roots pharmacy we contributed significantly to the breakthrough by our efforts. In fact I was told that at the first meeting of APhA and NARD representatives in November my statement that we must put aside the past and start afresh was quoted. With these initial successes, I think we must be vigilant that the harmony now being displayed in this new era of cor-

Maryland Board of Pharmacy News

— NOTICE —

The Maryland Board of Pharmacy will conduct an examination for registration as Pharmacist at the School of Pharmacy, University of Maryland, 636 West Lombard Street, Baltimore, Maryland.

On Thursday and Friday
November 29 and 30, 1973

The examination will begin at 8:00 a.m. each day. Applications must be in the hands of the Board by Monday, November 19, 1973.

Pharmacy Changes

The following are the pharmacy changes for the month of August:

New Pharmacies

Duren and Tucker, Inc., Chauncey L. Duren, President; 8901 Palmer Highway, Landover, Maryland 20785.

Read's, Inc., Arthur K. Solomon, President; 200 Radecke Avenue, Baltimore, Maryland 21206.

Cherry Hill Pharmacy, Inc., Samuel Kouzel, President; 11430 Cherry Hill Road, Beltsville, Maryland 20705.

No Longer Operating As Pharmacies
None.

Changes of Ownership, Address

Garwyn Ethical Pharmacy, Weslyn N. Shelton, President (Change of pharmacy name and ownership); 2300 Garrison Boulevard, Baltimore, Maryland 21216.

Bel Air Apothecary, Inc., Don L. Bradenbaugh, President (Change of address); 414 South Main Street, Bel Air, Maryland 21014.

dial and civilized relations between APhA and NARD official families shall not be short-lived.

Our other committees have also been active during the past year. Dick Fowler and his Industry Relations Committee have achieved positive results through well-conceived surveys. Roger Cain and Lou Sesti deserve our thanks for their work as program chairmen responsible for some outstanding programs.

As to recommendations to my successor, Henry Speckman, I would like to urge the appointment of a committee to review the role of NCSPAPE and the functions of its secretary.

I am grateful for the cooperation of the officers, executive committee members and particularly to Secretary Reed Bement for his dedicated efforts. Finally, I want to express my appreciation to all the members for their support and assistance. It has truly been an honor and privilege to serve as your president during the past year.



Legend drugs
in their own time

Family Planning:

A Springboard For The Pharmacist Into The Consumer Health Education Arena.

by SAMUEL H. KALMAN, R.Ph.

Program Planning and Technical Services Officer
Virginia Regional Medical Program,
Richmond, Virginia

Presented at the workshop—"The Pharmacist: Vital Link in the Delivery of Family Planning Services"—sponsored by the Maryland Pharmaceutical Association and The Planned Parenthood Association of Maryland, Baltimore Maryland, 7 June 1973.

Pharmacy is experiencing an era in which new roles are being suggested for the practicing pharmacists. Many of these roles are associated with the clinical pharmacy concept and focus primarily on patient care. Whether there is total agreement with all the implications for change embodied in this current trend is unimportant. What is important is that pharmacists understand that they must participate actively in rendering services which assist in bringing about optimum health for their patients.

It is becoming increasingly obvious from several quarters that the review of the quality and appropriateness of patient services will be significant. Events such as (a) the increase in third-party payment for prescriptions, (b) the advent of some form of national health insurance, (c) the extended coverage allowable under the new Social Security amendments, and (d) the establishment of the Professional Standards Review Organization should have significant meaning for pharmacy. For ultimately, it will be the quality and appropriateness of the services rendered that will decide which health professionals are required. What is being suggested here is that pharmacists begin to render services which are necessary and visible.

In addition to the obvious objectives, a well conceived service should recognize the personal worth of each patient and his individual responsibility in making decisions. In this regard, and how it relates to family planning, the remarks of Howard Freeman of Brandeis University are pertinent: "There is the beginning of a ground swell, at least on a verbal level, to raise the worth of man: insure his privacy, avoid treating him as a number, . . . and allow him to decide for himself when life is too insufferable to live, whether his child is to be born, and what drug he uses to escape from himself and others . . . The near future will certainly bring, for example, liberalized abortion laws in all states, . . . and acceptance of a wide variety of familial living arrangements . . . Zero population growth is now a common phrase, children are taught to spell contraception in the fourth grade, and birth control programs are rapidly becoming universal. The social structure is more than ready for expanded activities along these lines as well as for more concern with the shape of the population distribution."⁽¹⁾

True, the foregoing is at most suggestive of value changes. However, pharmacists should not wait for regulations and legislation in order to act. The area of family planning provides an excellent opportunity for the pharmacist to provide his patient/customer with information which would enable him to make an intelligent decision based upon available alternatives. Such decisions could have an immediate influence on the life-style of today's customers.⁽²⁾

Family planning is, in and of itself, a logical concern of the pharmacist because of its place as an integral part of health care. However, beyond its being an extension of his professional responsibility, the pharmacist stands to benefit from his involvement in family planning activities by developing the rapport necessary to establish a firm pharmacist-patient relationship. From that base he will be ready to assume additional functions as a community health educator, a resource which is needed in all communities.

In addition, as the health professional who would be referring customers to family planning clinics for services which are not available in the pharmacy setting, the pharmacist would be identifying himself as a "gateway" to the medical care system for many potential patients who would otherwise be reluctant to encounter the public health image of bureaucracy. This activity, whereby the pharmacist performs a "triage" function, has been given considerable attention and warrants further development elsewhere.

There is always the problem of who in the community pharmacy has the time for these additional activities. The pharmacy clerkships in Maryland and around the country provide an opportunity to experiment, to practice in a patient-care environment, as well as to see how knowledge can be turned into useful information—in a sense, to make the transition from theoretician to practitioner. A recommended activity in any clerkship is in the area of family planning.

A logical concern, and justifiably so, is how pharmacists and pharmacy students might be assisted in making such a transition. The following is recommended:

1. By reading on the subject. Several good booklets are available, e.g., "Contraceptive Technology."⁽³⁾
2. By arranging for and attending sessions conducted by local family planning clinics.
3. By taking advantage of opportunities in the pharmacy to talk with customers to find out their concerns.
4. By discussing ones ideas with other pharmacists and pharmacy students.
5. By experimenting with novel instructional approaches, such as using anatomical models.
6. By getting the endorsement and approval of local pharmacy groups and planned parenthood groups.

The following are five "models" of involvement for active participation by pharmacists in family planning activities. They are offered as suggestions.

I. At a very basic level, the pharmacist can simply post in his pharmacy a list of family planning services that are available in the community. (It could include private doctors, clinics—free and sliding scale, costs, and services.)

II. As an additional service, he can insert family planning literature in packages along with his customer's purchases. This would not be specific information about contraception but notification of information availability. (To do otherwise would be an assumption of the attitude of the pharmacist's clientele. An attitude should stem from choice of alternatives through education.)

III. The pharmacist can provide family planning information at the point of purchase of contraceptive products. The following are some of the areas which could be covered:

- A. Product availability and the effectiveness of each.
- B. Methods of contraception not requiring a physician's prescription.
- C. Methods of contraception which require a physician.
- D. Additional instructions on the use of non-prescription contraceptives.

IV. In addition to steps I, II, III, the pharmacist can display contraceptives separately from other feminine hygiene products. (One of the problems confronting the purchaser is his ignorance as to which product constitutes a spermicide or which creams and jellies can be used with a diaphragm/without a diaphragm. It is quite possible, although statistics are not available, that many a customer has purchased something on the order of KY Jelly, a lubricant, believing it to be a contraceptive jelly. The fault for this type of error may lie partially with the manufacturer who does not clearly and conspicuously label his product for what it is. Much of the fault, however, must be borne by the pharmacist who displays contraceptives, lubricants, feminine antiseptic and hygiene products together. Much of the concern over product selection, therefore, could be alleviated if contraceptive products were displayed in a distinct location.)

V. A complete and separate "center" for family planning products and information can be established (preferably close to the prescription department where the pharmacist is accessible). The "consulting area" may utilize tape decks, slide projectors, charts, illustrations, etc.⁽⁴⁾ This, of course, is the ideal "model" which allows for the greatest amount of involvement on the part of the pharmacist. This is not to say that it should be the immediate goal of each pharmacist. What is being suggested is that each pharmacist experiment with the simpler approaches, modify them to his individual practice, and incorporate the more complex steps as he becomes more involved and more comfortable in his role in family planning.

Whatever the extent of the involvement, however, there are a number of important guidelines to consider when providing family planning information.

1. Information should be delivered in as private and dignified a setting as possible. Empathy and thoughtfulness are important (particularly for the embarrassed unmarried who might feel uncomfortable buying contraceptives). In addition, family planning information should be available without jeopardizing the user's anonymity. Printed materials and visuals should be used effectively to share family planning information in a way which would guarantee patient/customer anonymity. However, it is important that the issue of anonymity not be interpreted as suggesting impersonal approaches.

2. The pharmacist should avoid putting himself in a position whereby he will be making judgments. His role is to inform and then support the decisions made by the patient/customer.

In summary, pharmacists, as members of the health care team, have a logical concern for their patients' physical health. Of equal importance should be a concern for improving the quality of life of all members of the community. Pharmacists exercising responsibility in the area of family planning is a start in the right direction.

References

1. Freeman, Howard E. "Technology and the Human Services Arena." DHEW Publication No. (HSM) 73-3016.
2. The Public Affairs Committee of the American Pharmaceutical Association recommended to the House of Delegates that "The Association encourage voluntary participation of pharmacists in individual or organized activities relating to family planning." (APhA Newsletter, 23 June 1973.)
3. The Emory University Family Planning Program, Department of Gynecology and Obstetrics, Emory University School of Medicine, Atlanta, Georgia.
4. This section would have many other uses as it relates to other areas of health education in which the pharmacist could rightly function—dissemination of information pertaining to the prevention of disease, counseling about o-t-c's, etc.

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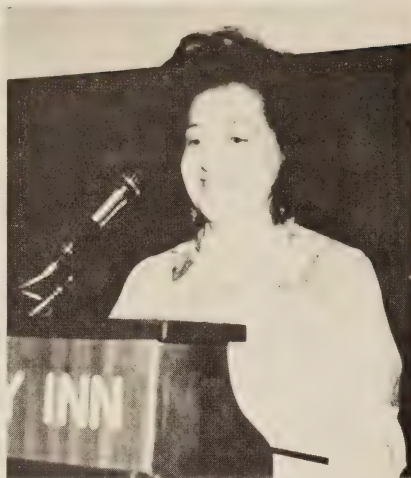
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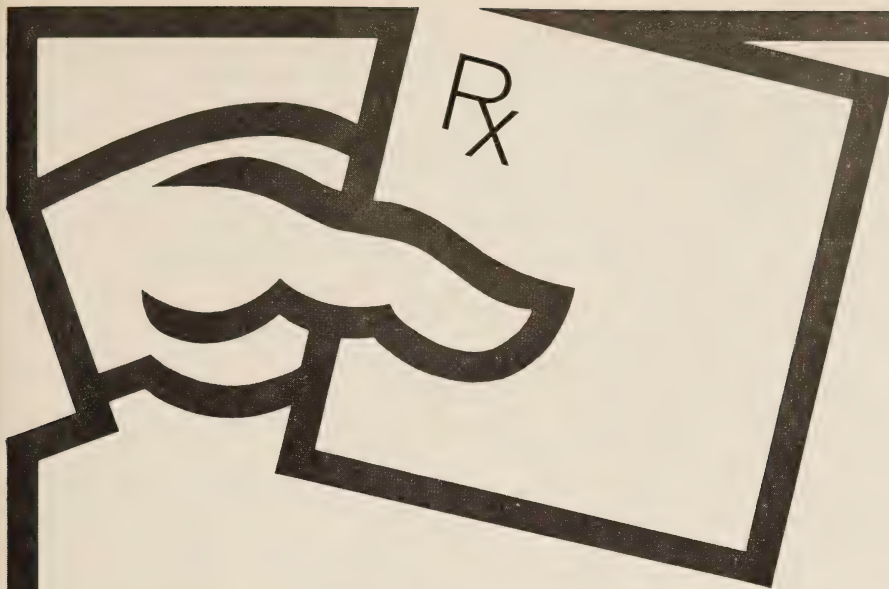
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MPhA Convention Photo Coverage . . .



Top Left—Anthony G. Padussis (l) installed as MPhA president by Installing Officer Charles B. Spigelmeier. Top Right—Mrs. Anthony (Arlene) Padussis, President of LAMPA. Middle Left—Honorary President Morton Schnaper (r) presented with plaque by Executive Director Nathan Gruz. Middle Right—John C. Matheny, President, TAMPA (Travelers Auxiliary). Bottom Left—University of Maryland School of Pharmacy report presented by Dean William J. Kinnard, Jr. Bottom Right—Outgoing President Bernard B. Lachman (r) receives past president award from President Padussis.

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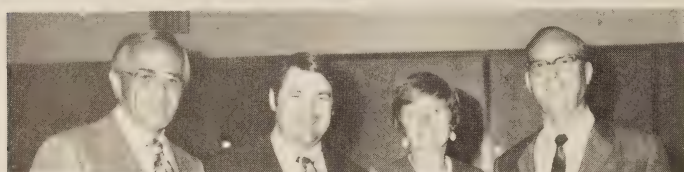
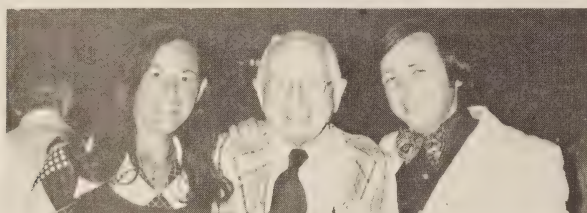
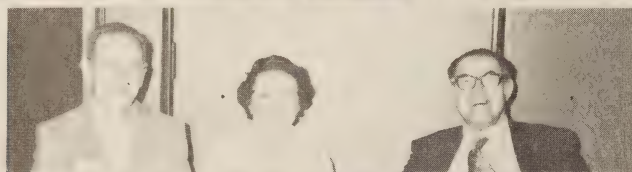
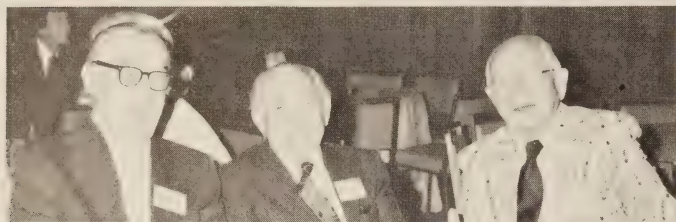


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Scenes at the Presidential reception at the 1973 MPhA annual convention. Hosted by Youngs Drug Products Corp.



—Photo by Paramount Photo Service

Scenes at three workshops "The Pharmacist and the Consumer," jointly sponsored by MPhA and the APhA Academy of the General Practice of Pharmacy. Group Leaders were: Mr. Vincent dePaul Burkhardt, Donald O. Fedder, Dr. Benjamin Hodes, PhD, Mr. John Kenny, Jr., Mr. Norman J. Levin, and Mr. William McGhan.

LAMPA Convention

Highlights

Friday, June 29, 1973

Members of the Ladies Auxiliary of the Maryland Pharmaceutical Association were the guests of Maryland Blue Cross-Blue Shield at their new building on Joppa Road in Towson.

After lunch in the Executive Dining Room, which afforded us a beautiful view of the Towson-Dulaney Valley area, we journeyed to the roof of the "glass cube" — as we quickly named the building. There, despite a slight haze, we had a truly panoramic view of Baltimore.

The computer area, which is usually off limits, was our next stop. The remarkable speed with which a BC/BS account can be verified was demonstrated to all members who had their identification cards with them. It was fun seeing your account flash on the TV tube as soon as the number was punched in.

Our final stop, the drug claim processing center, impressed upon us the need for accurately completing claim forms. Judging from the attractive, competent girls handling our claims—they are in good hands.

Somewhat awed by the building and its contents, both human and mechanical, we departed, impressed and pleased that we had accepted the invitation extended to us by Stuart Baltimore, Director, Special Benefits Division.

Saturday, June 30, 1973

LAMPA held its 20th Annual Convention Meeting at the Hunt Valley Inn, Cockeysville, Maryland. The following Officers and Board Members were elected:

1973-74

President	Mrs. Anthony G. Padussis
Communications Secretary	Mrs. Richard R. Crane
Recording Secretary	Mrs. S. Ben Friedman
Treasurer	Mrs. Harry L. Schrader
Membership Treasurer	Mrs. Bennie G. Owens

BOARD

Mrs. Frank Block	Mrs. Nicholas Lykos
Mrs. Morris L. Cooper	Mrs. Bernard Levin
Mrs. Joseph U. Dorsch	Mrs. Kenneth Mills
Mrs. Joseph J. Hugg	Mrs. Louis M. Rockman
Mrs. Charles E. Spigelmire	

The traditional souvenir, given to members attending the meeting was somewhat unique—a recipe collection. Thirty-six members contributed to the 76 recipes that make up "LAMPA's Favorite Recipe Collection." Many ethnic backgrounds found among our members are reflected in the "Collection." We have Gefulte Fish, Italian Spaghetti Sauce, Polish Sausage and Sauerkraut, Moussak a la Grecque, Lithuanian Kugel, Carrot Pudding and Grape Pie. Norman Lee Schwartz was presented the



At the Presidential Reception held at the Annual Convention of the MPhA on June 30, 1973 at Hunt Valley Inn were: (l. to r.) BMAPA President Paul Freiman, Executive Director Nathan I. Gruz, Incoming President Anthony G. Padussis, Outgoing President Bernard B. Lachman and Past President Nathan Schwartz.

first copy of the Collection, since her recipes were the first received.

It was a little like Christmas in June; we had numerous door prizes and every member won at least a prize. Our Treasurer, Mrs. Dorothy Austin, and our Membership Treasurer, Mrs. Sadie Wagner, both of whom retired from office, were presented silver bud vases, appropriately engraved. Our outgoing President, Mrs. Dora Rockman, was presented a sterling card plate, engraved to recognize her three years in office. Ann Crane—your reporter—was given a Delft blue and white Maryland Apothecary Jar.

Four new members were selected for membership. They are: Mrs. Dolores Dowling, Mrs. Diane Possner, Mrs. Virginia Watkowski and Mrs. Zelda Weiner.

Our program featured Mrs. Katherine Chin, Registered Dietitian. We not only learned about the various ingredients that are used in Chinese cuisine, but saw examples of many exotic and unfamiliar ones. The Chinese way of cooking rice was carefully explained, as well as the differences and uses of the long, short and glutinous rice. Should you see any of our members shopping for sea cucumbers, cloud ears, golden needles or mung beans, she has a Chinese treat in mind. The lively question and answer period was most informative and dispelled a few food myths. Mrs. Chin gave us a sign reading "LAMPA" in Chinese characters.

Sunday, July 1, 1973

LAMPA had its second art exhibit from 11 a.m. to 1 p.m. The artists were: Mrs. Sadye Friedman, Mrs. Camilla Ogrinz, Mrs. Arlene Padussis, Mrs. Margaret Pokorny and Mrs. Sophie Swiss. The fine quality of the work was obvious, the quantity displayed commendable and the variety of subjects most interesting. We applaud and congratulate our artists for the beautiful pictures they have created.

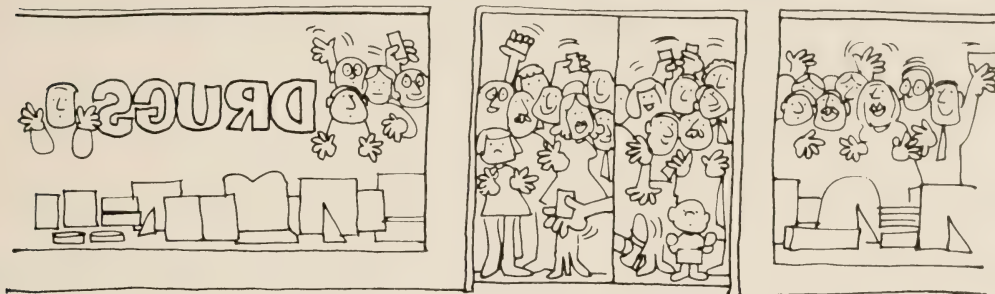
(Continued on Page 28)

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So stock up on Empirin Compound before the deluge. We have a hunch you'll be glad you did.



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Every time a patient brings you an Rx or asks you to recommend an OTC medication—that's an opportunity for you to help keep variables from interfering with drug therapy.

For example, a patient hands you an Rx, the third in one week from as many physicians. At that moment, you are in an ideal situation to evaluate certain variables which may interfere with therapy. Is there a possibility of drug incompatibility? Diminished therapeutic effects? Contraindications? You are in a unique position with specialized knowledge to exercise the last control, whatever the therapy.

And today, your professional expertise is in greater demand than ever . . . as knowledge accumulates about the complexities of multiple drug treatment . . . as more sophisticated products appear . . . as more patients self-medicate . . . all increasing the need to exert extra vigilance for the best possible health care.

Let's take a closer look at the many variables you can keep from interfering with drug therapy.

***As the last
professional seen
by the patient,
you can keep variables
from interfering with drug therapy.***



You

The variable of multiple physician prescribing.

Many patients see more than one physician. For example, in a recent study of 75 patients, 33 received Rx's from two or more physicians and used multiple medications in a 30-day period! Let "surprisingly, the tendency to obtain prescriptions at different pharmacies was not as prevalent as had been expected."¹ The majority of patients, fifty-two (86.7%), obtained them from one pharmacy; and only eight (13.3%), from two pharmacies¹—such a situation represents an ideal opportunity for you to compile an accurate prescription profile that permits double-checking to rule out drug antagonism or contraindication. That's keeping a variable from interfering with therapy. That's the last control.

The variable of self-medicating.

While Americans utilize many OTC drugs, a great many patients make no mention of them to their physicians. Further, a patient may use several different OTCs, sometimes in combination with one or more Rx products. You can put it all together into a medication profile from which you can guide the patient to safer usage. That's keeping a variable from interfering with therapy. That's the last control.

The variable of multiple drug dispensing.

You have the opportunity to prevent adverse drug effects. Hospital admissions due to drug intolerance or overdose or from interaction of two or more chemically or physiologically incompatible drugs have been reported.² You can play a pivotal role in prevention. You can be the right person, at the right place, at the right time. You can ascertain correctly from the patient's medication record whether an undesirable drug interaction is likely. That's the last control.

The variable of eating and drinking.

Suppose a patient hands you an Rx for an MAO inhibitor. An inquiry about the physician's instructions plus an extra reminder from you not to drink alcohol or eat tyramine-containing foods like aged cheese could prevent a serious hypertensive crisis. On other occasions some common foods taken with drugs may also produce adverse effects. But with your added advice, eating and drinking need not interfere with therapy. That's the last control.

The variable of drug borrowing.

The use of Rx drugs by the patient's friends and relatives is not uncommon.¹ And, when asked, patients often feel no compunction in disclosing drug borrowing. So when a patron tries to refill someone else's Rx, a simple question may reveal the extent of self-prescribing and self-medicating with borrowed drugs—a course which you can promptly discourage while offering a better alternative. That's the last control.

The important variable: You.

As a health care professional, with expert knowledge of drug interactions, you are in a key position to help minimize the possibility of untoward drug effects.

Unfortunate interactions may occur when a patient ignores or forgets his physician's instructions, when a concomitant OTC purchase is made without the physician's knowledge, or when prescriptions are written by more than one physician, with neither physician made aware of the other's actions. In such situations, *you, as the last control, can minimize the interference of such variables with drug therapy.*

References: 1. Stewart, R. B.: *Hospital Pharmacy* 7:108, April 1972. 2. Krupp, M. A.: *Group Practice* 21:22, Nov. 1972.

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are the last control.

University of Maryland

School of Pharmacy

Dr. William J. Kinnard Jr., Dean of the School of Pharmacy, University of Maryland at Baltimore, (UM-AB), announced recent appointments and promotions at the school.

Dr. Thomas H. Wiser has been appointed Instructor in Pharmacy and will work jointly with the Office of Health Care Services, Department of Social and Preventive Medicine at the School of Medicine. Under the direction of Dr. William S. Spicer, Dr. Wiser will support patient care activities in the primary care and adult screening units, and will carry out teaching activities in the Primary Care Nurse Practitioner Program. Dr. Gary M. Oderda has also been appointed Instructor in Pharmacy, as well as Director of the Maryland Poison Information Center. He will bear responsibility for directing the day-to-day operation of the Poison Information Center at the pharmacy school and will establish a clinical clerkship for pharmacy students in the emergency rooms of the University of Maryland Hospital and Johns Hopkins Hospital.

Dr. Michael D. Loberg has been appointed Assistant Professor of Pharmacy and Medicinal Chemistry at the School of Pharmacy jointly with the School of Medicine, as Assistant professor of Medicine in the division of nuclear medicine. At the pharmacy school, Dr. Loberg will be responsible for the course work in the area of radiopharmacy.

Also appointed Assistant Professor was Dr. Arlene Fonaroff, who will be in the department of Pharmacy Administration and will be involved in research to aid consumers of pharmacy services.

Dr. David L. Heeran has been appointed jointly by the School of Pharmacy and the School of Medicine. At the pharmacy school, he is Instructor in Pharmacy. He is Instructor in Clinical Pharmacy at the medical school, and will be involved in the clinical pharmacy phase of family medicine.

Gordon A. Ireland has been appointed Associate in Pharmacy and will be involved in teaching in the hospital ward experience program for the Division of Clinical Pharmacy.

Jacquelyn S. Lucy, formerly with the Anne Arundel County Board of Education has been appointed Poison Information Officer of the Maryland Poison Information Center.

Rachel Z. Booth, Associate Director of Nursing Ambulatory Services, has been appointed Clinical Assistant Professor at the School of Pharmacy to assist in developing the team concept in the primary care unit.

Dr. Edward J. Kowalewski, head of the family practice program at the School of Medicine, has been ap-

pointed Clinical Professor of Pharmacy, in recognition of the collaborative work between the pharmacy school and the medical school's Division of Family Practice.

Dr. William S. Spicer, Associate Dean of the School of Medicine, has also been appointed Clinical Professor of Pharmacy in recognition of the collaborative work between the Office of Health Care Programs and the School of Pharmacy.

Adjunct appointments include Dr. Deanne E. Knapp, currently technical information officer in medical communications at the Food and Drug Administration, who has been appointed Adjunct Associate Professor of Pharmacy Administration; and Ralph Engel, appointed Adjunct Assistant Professor of Pharmacy Administration, who will assist the pharmacy school with research in the area of third party payment services.

Promotions at the School of Pharmacy include:

Dr. Gary G. Buterbaugh, promoted to Associate Professor of Pharmacology in the Department of Pharmacology and Toxicology.

Dr. Anthony S. Manoguerra, promoted to Assistant Professor of Pharmacy.

Arthur N. Riley, promoted to Clinical Assistant Professor of Pharmacy.

School of Pharmacy/Hospital Exhibit At Boston Convention

Among the scientific exhibits at the American Pharmaceutical Association convention in Boston, Massachusetts, July 21-27, certainly one of the most attractive and attention arousing was the cooperative display of the University of Maryland Hospital and School of Pharmacy.

The exhibit featured an audio visual presentation of the scope of pharmacy programs which are under way at the University of Maryland. Emphasis was placed on the Pharmacy's professional experience program and the patient orientation services of the Institutional Pharmacy Department of the University of Maryland Hospital. Material relevant to the presentation was available to visitors at the booth.

Featured on a three panel backdrop of the exhibit was a pictorial record of activities in the component parts of the program. An original audio tape was made for the exhibit; it will be used for future similar presentations. Exhibit details were arranged by Mr. Arthur Riley, Assistant Director of Pharmacy for Ambulatory Services University of Maryland Hospital, and his committee. Mr. William Edmondson served with this committee for the School of Pharmacy.

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Pharmacy School Seeking To Meet Minority Shortage

The Office of Minority Affairs at the School of Pharmacy under the directorship of Michael W. Skinner was established to develop and implement effective recruiting and retention programs to attract significant numbers of minority students to the school and to the profession of Pharmacy because of the extreme shortage of black professionals in this area.

The priority of minority participation within both the school and the profession has been a major concern of the Dean of the school, Dr. William J. Kinnard, Jr., prior to the Department of Health, Education, and Welfare Grant Award in 1972.

Today, a little over a year after the first H.E.W. Award, Maryland has made considerable impact on recruiting and retaining the numbers of minority students in the school and on the community with an "on the road" recruiting and educational program.

The advent of the Office of Minority Affairs is a tremendously significant historical development in the relationship of blacks vis a vis pharmacy and portends to affect the lives of inestimable numbers of people.

Our aim is to afford the student an education which will provide academic background and an ethical educa-

tion which provides an understanding of the individual and his world.

While Blacks comprise 11 percent of the nation's population, only 4.8 percent of the nation's approximately 117,776 pharmacists are Black. There are less than 35 known Black pharmacists in the Baltimore Metropolitan Area and fewer than 10 are graduates of the University of Maryland. Why? Because minorities have been systematically kept out of the profession by the school which serves as the provider of trained pharmacists for the State of Maryland.

There are approximately 18,445 students studying pharmacy in this country, 659 of whom are Black and 372 are enrolled in predominantly Black educational institutions. The remaining 287 are enrolled in 55 other colleges.

The University of Maryland School of Pharmacy "has affirmed its intent to recruit increased numbers of minority students by modifying its admissions policy. This policy now specifies that an enrollment of minority students must reach at least 20 percent of the school's enrollment by 1974." The Black student enrollment figure is approaching 15—one third the number required to meet the 20 percent goal for 1974.

We understand our twin responsibilities to give the best possible training and to create alternative devices to motivate and encourage more Black youth in pharmacy, the vanguard of our need for change.

**Rx If you are a pharmacist-
or about to become one-**

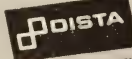
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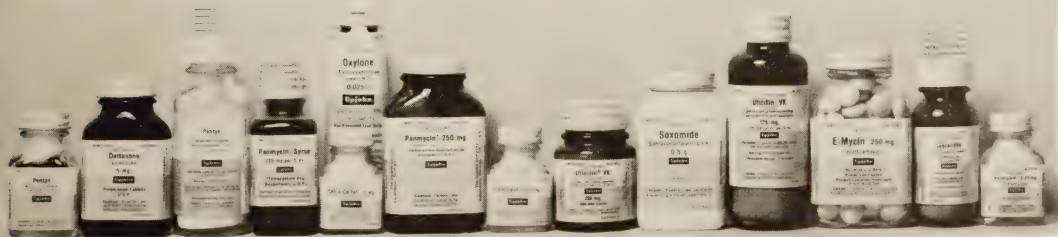
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Baltimore Metropolitan Pharmaceutical Association

A general meeting of the Baltimore Metropolitan Pharmaceutical Association was held on September 20, 1973 at the Towson Plaza Garden Room. The guest speaker was Dr. R. L. Wolen of the Eli Lilly Laboratory for Clinical Research. Dr. Wolen, a dynamic speaker and nationally recognized authority on bioavailability, gave a slide presentation entitled "Drug Products and Bioavailability: What Every Pharmacist Should Know."

President Paul Freiman opened the business meeting with a report on the APHA Convention. Other items discussed were the September 11 Employee Pharmacists meeting, legislation, the prescription price survey conducted by the Junior League and the October 11 Fall Regional Meeting to be held at the Cross Keys Inn.

Melvin Rubin and Bernard Lachman were appointed by President Freiman to work with the Public Relations Committee of the Junior League. Ronald Lubman is working with problems of forged prescriptions.

Executive Director Nathan Gruz reported on the Court of Appeals hearing on the Advertising Law. Jerome Mask is handling administration of the Pharmaceutical Services Foundation program on a part-time basis.

EMPLOYEE PHARMACISTS MEETING

Dennis Klein, Chairman of the Employee Pharmacists Committee, reported on the meeting of September 11 held at the Quality Inn Northwest. The "rap session" brought out employee problems centering on lunch breaks, number of prescriptions filled per day, supervision of technicians and employee benefits. Other members of the Employee Pharmacists Committee are: Barry Bloom, Mark Levi, Burt Shevits, Morty Silverstein and Kenneth Sumida.

Melvin Rubin reported on third party payment programs. The problem of blank prescriptions being distributed by one plan was reported. John Kent, newly appointed Secretary of Health for Medicaid was contacted about the temporary card problem.

Eastern Shore Pharmaceutical Society

The Eastern Shore Pharmaceutical Society held its annual Crab Feast at Chamber's Park in Federalsburg, Md. on August 5, 1973. William Smith and James Truitt were hosts for the affair which helped raise money for the Society's Scholarship Fund.

Anne Arundel Pharmaceutical Association

Officers of the newly organized Anne Arundel Pharmaceutical Association are as follows:

President	Milton Watkowski
First Vice President	Ben Owens
Second Vice President.....	Maurice Rungartner
Treasurer	Robert Harnish
Secretary	Roberta Van Duzer

News from Gilpin



ROBERT F. KAVAN

Gilpin Appoints Kavan Executive Vice President

Mr. Robert F. Kavan has been appointed Executive Vice President of the Gilpin Wholesale Drug Company, a division of the Henry B. Gilpin Company. Mr. Kavan will have overall responsibility for direction of the Company's wholesale drug facilities in Baltimore; Dover, Delaware; Memphis, Norfolk, and Washington, D.C. Mr. Kavan was formerly Executive Vice President of Ketchum Distributors, Inc.

Turner Promoted At Gilpin

The Henry B. Gilpin Company, a distributor of health care products with headquarters in Washington, D.C., announces the promotion of Edward Al Turner to Assistant Branch Manager of its Baltimore, Maryland wholesale drug branch.

Mr. Turner joined Gilpin in 1956 and, during his 17 years of service with the company, he has functioned in all areas of internal operations and customer services. His extensive background in the pharmaceutical distribution industry will contribute extensively to his new responsibility for providing the highest quality service to Gilpin customers in the Baltimore market.

Support Your Associations
"In Unity There Is Strength"

The only thing worse than being ill, is being bored

The cold and flu weather is on its way. And most people can put up with the sneezing and coughing.

But finding something to do during all those hours in bed, that's a real pain.

A person can only stand those game shows and soap operas for so long, before all they want to do is lay back with something good to read.

Maybe a sports magazine, a hobby book, a paperback novel or a news magazine.

What medicine does for their body, reading does for their mind.

And at Maryland News Company we're proud to be

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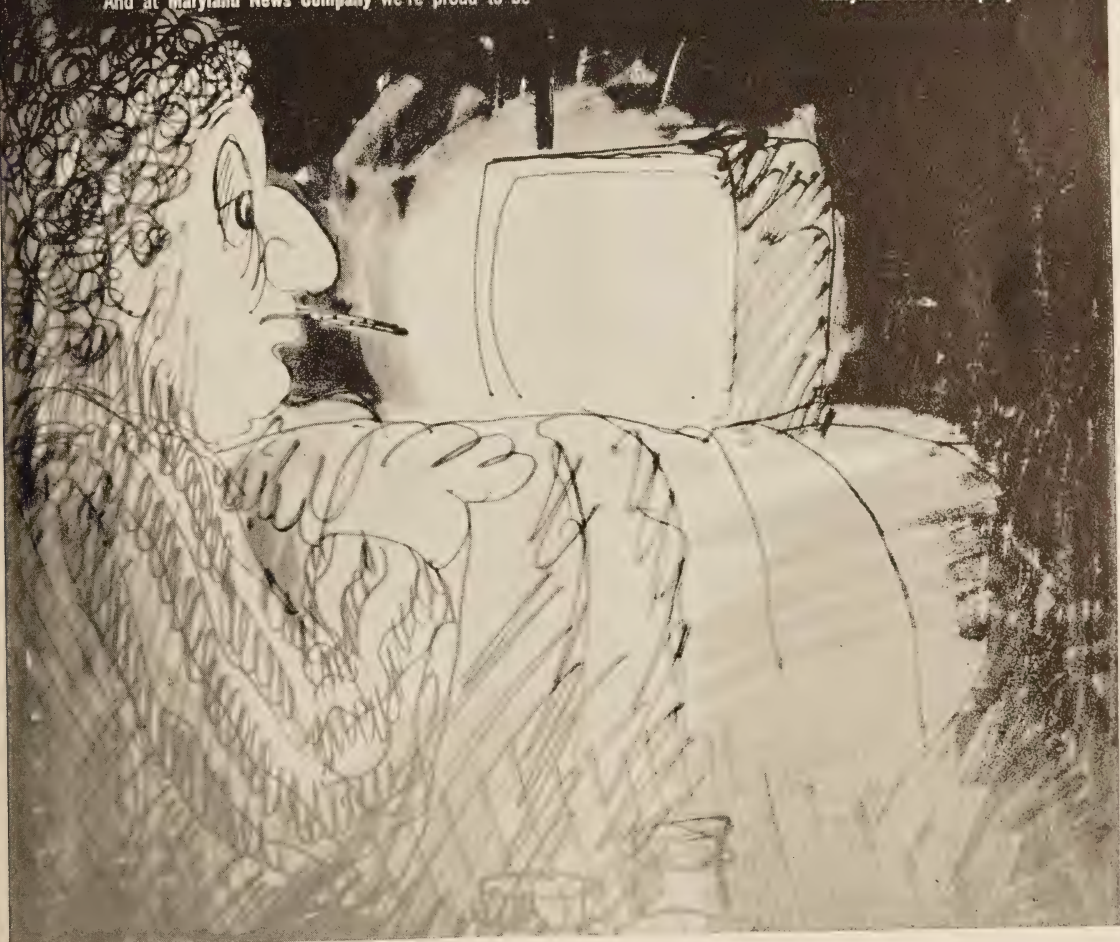
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Maryland Society of Hospital Pharmacists

ASHP Annual Meeting

The American Society of Hospital Pharmacists held its 30th Annual Meeting in Boston, Massachusetts on July 22-26, 1973 as one of the many organizations in Pharmacy meeting in conjunction with the 120th Annual Meeting of the American Pharmaceutical Association.

Thirty-six contributed papers were presented at three general sessions and there were two meetings of the ASHP House of Delegates. In addition the annual ASHP breakfast and annual Harvey A. K. Whitney Lecture Award Dinner were held. The 1973 Harvey A. K. Whitney Lecture Award was presented to George L. Phillips of Ann Arbor, Michigan.

Robert L. Lantos of Gainesville, Florida was installed as President. R. David Anderson was reelected and installed as Chairman of the House of Delegates. Other nominees for office to be elected by mail ballot are: for Board of Directors: Vincent Bouchard, Michigan; Willard Harris, Virginia; Kurt Kleinmann, New York; and David Zilz, Wisconsin. For President Elect: R. Paul Baumgartner, West Virginia; William Hotaling, Washington, D.C.

Two proposals were submitted by the Council on Organizational affairs. Proposal No. 1 would have removed from the by-laws the requirement that members of an affiliated state chapter be members of ASHP. This proposal was voted to be referred back to committee and will be presented for a vote at next years meeting. The second proposal changed the definition of an active member by eliminating from the Constitution the definition of "hospital pharmacist" and incorporating in its place an elaboration of the description of "active members." This proposal was passed and now must be submitted to the membership since it involves a constitutional amendment.

In addition, three resolutions were submitted by the Committee on Resolutions. A resolution pertaining to child resistant packaging recommended by the Missouri Society of Hospital Pharmacists was adopted. The resolution directs the American Society of Hospital Pharmacists to initiate immediate action to encourage the development of child resistant single-unit packages and dispensing containers for oral solids. A second resolution calling for the establishment of a western regional office of the ASHP was recommended by the California Society of Hospital Pharmacists. This resolution was referred to the Council on Organizational Affairs for further study with a report to be made at next years meeting. The third resolution pertained to the "Patient's Bill of Rights" as adopted by the American Hospital Association. This resolution was also recommended by the California Society of Hospital Pharmacists. The House of Delegates decided to refer this resolution to the ASHP-AHA Joint Committee.

Clinical Pharmacy Practiced in Rural Community Hospital

At the Eighth Annual Seminar of the Maryland Society of Hospital Pharmacists held in Ocean City, Maryland on June 16, 1973, Dr. Thomas S. Sisca, Pharm. D., described the clinical pharmacy program at his hospital.

Dr. Sisca is Director of Clinical Pharmacy Services at the Memorial Hospital in Easton, Maryland, a 230 bed non-profit, acute, general community hospital in a rural setting with a staff of sixty private physicians, no house staff, a school of nursing and an Emergency Care facility.

Dr. Sisca pointed out that this type of institution has been neglected by clinicians who either feel that a community hospital does not need clinical pharmacy or that private physicians will not accept such an individual.

He went on to say that Clinical Pharmacy has been well documented to play an integral role in health care at the university levels, however, many pharmacists are frustrated by this concentration and lack of importance placed on community institutions.

It was Dr. Sisca's opinion that the community hospital needs the services of a clinically oriented pharmacist much more than does a university center.

In describing his program and method of introduction and implementation the following points were stressed:

1. Careful planning
2. Adequate drug information resources
3. Careful selection of applicant for position
4. Good communications
5. Good drug delivery system
6. Access to the chart
7. Desire to work with the physician to offer the patient the utmost in therapeutics

The method utilized to introduce the program was described and various confrontations and their solutions were discussed. In the beginning there was much animosity towards him and his program, as there is to any form of change. It was not until he documented his usefulness by helping with a drug related disease manifestation, that the medical staff began to utilize him as a member of the health team.

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community involvement, patient drug histories, and an active role in choosing therapy are some of the aspects of the program.

Dr. Sisca stressed the importance of the Director of Pharmacy Services formulating the initial groundwork for the position and getting the program approved by Administration, Nursing, and Medical Staff, prior to his arrival. He urged directors of small hospitals who lacked the training or time to become clinically involved to initiate such a program, using his situation to illustrate that it can be done.

The program has developed in less than one year, to one which was beyond the expectations of all involved. Dr. Sisca is thought of and utilized as a Drug Therapy Specialist and is formally consulted concerning any problems in therapeutics such as side effects, drug interactions, therapy of choice, biopharmaceutics, etc. His playing an active role in therapeutics has been personally rewarding and gratifying.

The success of the program at the Memorial Hospital in Easton demonstrates the need of Clinical Pharmacy services in small community hospitals. Only when Clinical Pharmacy begins to branch out into the community and no longer concentrates and stagnates at the university level, will the true impact of Clinical Pharmacy on the total picture of health care be felt.

An extensive article describing the whole scope of the Easton Memorial Hospital program appears in the September, 1973 issue of *Hospital Pharmacy*.

LAMPA

(Continued from Page 16)

In the afternoon, a caravan of LAMPA members and guests arrived at Breezewood, the Monkton, Maryland estate of Alexander B. Griswold. After a look-see at the museum containing many ancient and valuable Buddhas, we leisurely explored the Oriental and formal gardens. This tour was a special treat and a sight many of us did not know existed in our State.

Members that attended any or all of our LAMPA activities seemed satisfied and are looking forward to our next bus trip. We plan to visit the Brandywine River Museum and a few other places—the date is Thursday, September 13, 1973.

Ann Crane,
Communications Secretary



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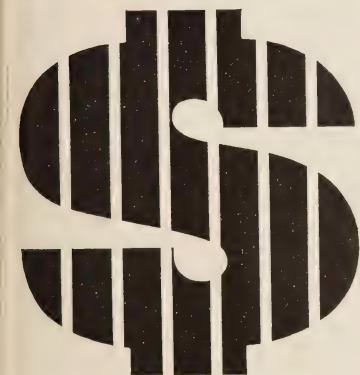
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COMMUNITY PHARMACY

OPERATIONS

1972



In the average *Lilly Digest* pharmacy, sales rose only 2.2 percent during 1972.

However, this modest increase was due solely to a sound gain in prescription revenue of 6.5 percent, which offset a decrease of 1.2 percent in other sales. This decline in merchandise-oriented activity is well worth watching during the coming years. It may be an indication of a major change in the sales mix of the average community pharmacy. If so, managers may tend to emphasize the prescription department and related areas to a greater degree than in the past and be less concerned with "front" merchandise.

Of major importance is that net profit again fell as expenses rose. Profit was 3.6 percent of sales—an all-time low. However, total income, the sum of net profit and proprietor's salary, rose to a new dollar high of over \$29,000. This was due to the larger sales volume and the fact that the average proprietor paid himself a salary of more than \$20,000.

Rent expense held steady at 2.5 percent of sales for the tenth consecutive year. To avoid misinterpretation, it should be noted that rent as well as all other expense items have moved up in dollars during the past ten years. When expressed as percents of sales, however, the trends do not necessarily (and generally do not) follow the dollar movements. Rent in 1963 totaled about \$3,500 and now exceeds \$6,000—a rise of over 70 percent.

Probably in an effort to control expenses, particularly wages, the average pharmacy was open fewer hours than during 1971—sixty-nine hours weekly. This adds to a downtrend that began some ten years ago, when the average pharmacy was open seventy-seven hours each week.

Inventory was well controlled at 17.1 percent of sales. The turnover ratio was 3.8 times during the year. Of primary interest is the productivity of the stock. The prescription inventory again improved its sales return as it rose to \$8.07. All other stock produced only \$4.70; this figure represents a downtrend.

In comparison with the 1971 ratio, it should be noted that the prescription department's share of total sales rose once again to an all-time high of 46.6 percent. This upward movement is of very long duration and reaffirms the leadership role of the professional area in the average community pharmacy operation.

Prescription activity rose to over 25,700. Since renewals increased less than 1 percent, the bulk of the increase was due largely to new prescriptions. This statistic should be watched in future editions of the *Digest* to determine whether a trend is developing. The average prescription charge increased 4 percent to \$4.38. As in past years, the *Digest's* objective is to provide comparative figures for pharmacists so that they can evaluate their own operations. It is not intended to be a model for economic predictions. However, these figures suggest that pharmacy is reorienting its main thrust from many small operations with a decided merchandising flavor to fewer pharmacies that are larger saleswise and have a dominant prescription emphasis. This change may be the result of competitive pressures or a general professional upgrading, or perhaps it is simply a short-term situation. At any rate, it will be studied with interest. It is abundantly clear, however, that tomorrow's successful pharmacist must concentrate on expense control, no matter what sales mix is evolved in the average pharmacy. □

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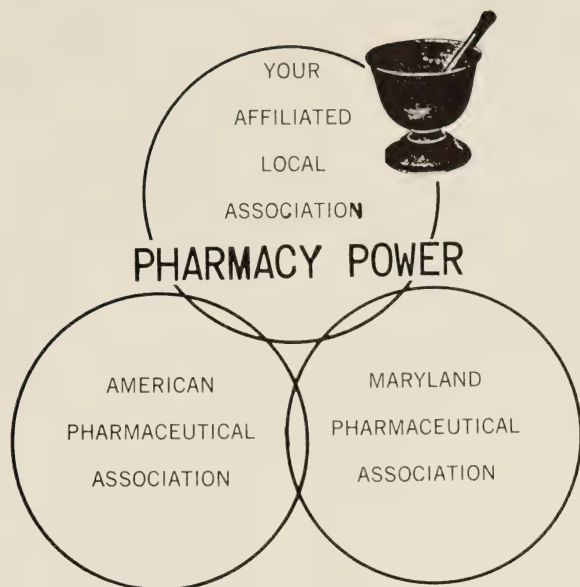
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SEPTEMBER

1973

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Advancing The Cause Of Unity —
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Editorial . . .

ADVANCING THE CAUSE OF UNITY

Will COPES Inaugurate Peace In Pharmacy?

The announcement that the American Pharmaceutical Association (APhA) and the National Association of Retail Druggists (NARD) have agreed to form a joint committee is certainly a step that can prove to be constructive in advancing the profession of pharmacy.

After years of anguished demands by pharmacists for cooperative action by APhA and NARD and with the prodding of the State Pharmaceutical Association executives, the two groups have agreed to work together in a specific area. The issue chosen is "Economic Security," with the major objective announced as seeking a resolution of the urgent problems facing the profession in "third party" prescription programs.

The inequities and maladministration of prescription pre-payment plans — both government and private — take up a large share of the resources of state associations and the time of staff and members. We earnestly hope that "COPES," the APhA-NARD "Committee on Economic Security," will be able to help solve the thorny problems facing pharmacists in meeting the harsh realities of economic forces and management requirements.

Unfortunately, developments in the relationship of APhA with the National Pharmacy Insurance Council (NPIC) resulting in the APhA Board of Trustees decision to sever its ties with NPIC seemed to be the impetus culminating in the agreement to form COPES. NARD had been the only major group unwilling to join NPIC.

It is sad that NPIC, which was launched by APhA and was endorsed with such great hope by almost all groups and individuals in pharmacy, has become a possible polarizing casualty of organizational rivalries and personality incompatibilities that have traditionally plagued pharmacy.

For the present, pharmacy is left with two organizational entities working on some of the same problems with overlapping scope and activities. Pharmacy's limited resources are again being fragmented. In addition, as in the past, governmental and private agencies are approached by more than one group as representative of the profession of pharmacy in a crucial area.

Pharmaceutical statesmanship of a high order will be required to resolve the consequences of APhA's original commitment to an "independent" council of all elements to represent pharmacy in the "third party" area with its subsequent decision to seek the dissolution of the new unit and replace it with a bilateral APhA-NARD committee.

We sincerely wish COPES will prove able to accomplish all of its announced objectives. We fervently hope that COPES will truly inaugurate an era of peace, progress and unity of pharmacy for the advancement of both the public interest and the profession.

—Nathan I. Gruz

PHARMACY CALENDAR

December 9 (Sunday)—University of Maryland, School of Pharmacy, Continuing Education Program, Antibiotics in Clinical/Pharmacy Practice. To be presented at the Sheraton Motor Inn, Route 40 at Junction Route 70, Hagerstown, Md. 9:30 a.m. to 4:30 p.m.

December 9-13—American Society of Hospital Pharmacists Midyear Clinical Meeting, New Orleans, Louisiana.

1974

January 27 (Sunday)—Second Annual Alumni Oyster Roast, University of Maryland School of Pharmacy Alumni Association, Overlea Caterers, 6809 Bel Air Rd., 1-6 p.m.

February 3 (Sunday)—Annual Installation Banquet, Baltimore Metropolitan Pharmaceutical Association, Blue Crest North.

February 18-24—Maryland Pharmaceutical Association "Holiday in Israel" with optional extension tour to Rome.

May 29 (Wednesday)—Graduation Banquet, University of Maryland School of Pharmacy, Eudowood Gardens.

June 23-27—92nd Annual Convention, Maryland Pharmaceutical Association, Downingtown Inn, Downingtown, Pa.

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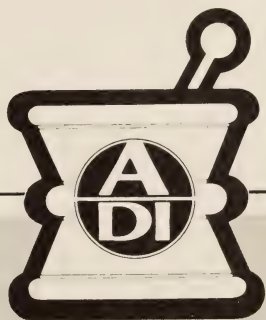
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MPhA In Action

Board of Trustees Meetings

NATHAN I. GRUZ, *Executive Director*

August 9, 1973

—Received communication from Baltimore City Police Department regarding Security and Crime Seminar to be held August 14.

—Received letter from LAMPA acknowledging assistance at MPhA Convention and advising of bus trip on September 13.

—Received letter from the Cosmetic, Toiletry, and Fragrance Association, Inc. regarding a Model Cosmetology Act. Referred to Legislative Committee.

—Approved President's report commenting on excellent program and House of Delegates session at APhA Convention. Also noted attendance at Eastern Shore Pharmaceutical Society Annual Crab Feast.

The President announced the following committee appointments: Convention — Paul Freiman, Chairman; Henry G. Seidman, Co-Chairman; Finance—Stanley J. Yaffe; Judicial Board—Norman J. Levin, Legislative—Paul Freiman, Chairman and Robert E. Snyder, Co-Chairman; Prescription Insurance Programs—Melvin N. Rubin; Professional Relations—Stephen Hospodavis; Public Relations—Charles E. Spigelmire; Peer Review—Irvin Kamenetz; Constitution and ByLaws—Victor H. Morgenroth, Jr.

—Approved Treasurer's report

—The Executive Director reported on his activities which included attendance at APhA Convention. There was controversy regarding the National Pharmacy Insurance Council (NPIC) and the Committee on Professional Economic Security (COPEs). MPhA delegates, in line with the policy of its House of Delegates, supported continued participation of APhA in NPIC. The School of Pharmacy was commended for the excellent exhibit on the Professional Experience Program at the APhA meeting.

—There was discussion on the APhA policy on dispersal of narcotics rather than segregation under lock or in a safe. The Esskay prescription plan processed by MPhA is increasing in volume. Problems of crime and forged prescriptions were noted. The State Medical Society (Med Chi) has again authorized a liaison committee with MPhA. Other activities included Peer Review Committee, conference with legal counsel, appearance before a committee of legislature on Medicaid and attendance at Board of Pharmacy meeting.

—Announcement was made of continuing education cassette tapes available from School of Pharmacy and of a seminar on "The Pharmacist as a Consultant to Hospitals, Nursing Homes and Extended Care Facilities" September 21 and 22. The Prince Georges-Montgomery County Pharmaceutical Association has asked about the possibility of MPhA handling mailings. A report on

the highlights of the Board of Pharmacy meeting was given.

The Executive Director also reported on various third party plans and foundations. Delegate John Kent, recently appointed Assistant Secretary of Health for Medicaid, was contacted. Problems of temporary cards and the Pharmacy Subcommittee were reviewed. The Executive Director reported that a compilation of third party programs has been prepared by Melvin Rubin and Jerome Mask.

—Approved Membership Committee report

—Approved a contribution of \$250.00 to the North Dakota Pharmaceutical Association to assist in the pharmacy ownership court case.

—Received report of Convention Trip Chairman on status of Israel Trip in February, 1974 and a proposal for trip to Caribbean in May, 1974. Noted conflict of May trip with June convention. Requested chairman to report again in September on the proposed May 1974 trip.

—Heard School of Pharmacy report. The Dean commented on faculty changes and Pharmacy Subcommittee of the Medicaid Program. He stated that 90 students including 38 women were entering school.

—Endorsed the concept of COPEs.

—Received Convention Committee report noting that the Fall Regional meeting would be held October 11 at Cross Keys Inn and that the 1974 convention will be held June 23-27 at Downingtown Inn.

—Approved appointment of Robert E. Snyder to fill vacancy of President-Elect Freiman as Trustee.

—Agreed to set up a joint MPhA-MSHP Committee on Nursing Home Pharmacy Services to investigate the current situation, set up standards, require a pharmacist for each home as "Director of Pharmacy Services" as responsible person and permit compensation not based on percentage, but on a per diem factor.

—Rejected proposal to endorse Medicaid co-pay policy coupled with mandatory collection. Voted against co-pay principle for reasons stated in analysis by State Legislature Committee.

—A request from member M. Neal Jacobs for publication of a letter citing grievances against inspectors from the State Department of Health Division of Drug Control was not approved by the Editor. The decision was concurred by legal counsel and referred for further review by the Board of Trustees.

—Authorized legal counsel to submit an *amicus curiae* brief in the prescription advertising case of Board of Pharmacy vs Sav-a-Lot before the Court of Appeals.



Legend drugs in their own time

Maryland Pharmaceutical Association House of Delegates Meeting

Hunt Valley Inn, Hunt Valley, Md.

June 30, 1973

MINUTES

First Session

The meeting was called to order by Speaker Henry G. Seidman at 10:30 A.M. Secretary Gruz conducted the roll call and stated that a quorum was present. The minutes of the previous meeting were distributed. Reading of the minutes was dispensed with upon motion of Dr. William J. Kinnard, duly seconded and passed.

Speaker Seidman announced the appointment of the following Resolutions Committee of the House: Victor H. Morgenroth, Chairman; Morris Bookoff, John McHugh, James Truitt.

Dean Kinnard then delivered a report on the University of Maryland School of Pharmacy. He outlined plans for the future and also stressed the need for MPhA and Maryland Society of Hospital Pharmacists (MSHP) "to get together."

Dr. Peter P. Lamy then addressed the House regarding cooperative activities between MSHP and MPhA. He urged three areas for consideration: Peer Review, Legislation and Continuing Education for possible joint committees. There was then discussion of a proposed model institutional pharmacy act that has been drafted by the American Society of Hospital Pharmacists and presented at the MSHP Annual Seminar. Work along these lines has grown out of MSHP and the "Suggested Principles and Guidelines for Pharmaceutical Services in Hospitals" developed by various concerned groups including MPhA.

This was followed by the Board of Canvassers report delivered by Joseph U. Dorsch in the absence of the Board of Canvassers chairman, Dr. Benjamin Allen. The results of the election were as follows: Vice President: Henry G. Seidman; Trustee: James W. Truitt, Jr.; Trustee: Richard D. Parker.

President Lachman then introduced Captain Preston D. Rowland of the Maryland State Police. Captain Rowland and his assistants Lt. George Snyder, Lt. Skinner, Sgt. Ingram and Det. Winchester presented a panel program entitled "Security Problems and the Pharmacist." The session recessed at 12 noon.

Sunday, July 1

Second Session

Speaker Seidman called the second session of the House of Delegates to order. Donald O. Fedder was appointed Parliamentarian. Upon motion of Nathan Schwartz, seconded by Alder Simon, the rules of order were suspended to allow old business and new business to precede reports.

A pending amendment of the Constitution (Section 1, Article IV) to add the Vice Speaker of the House of Delegates as a full voting member of the Board of Trustees was approved.

Victor H. Morgenroth, Chairman of the Resolutions Committee, presented the following resolutions.

- 1) A resolution introduced by the Prince Georges-Montgomery County Pharmaceutical Association regarding steps to be taken to reduce the danger of pharmacy burglaries. Passed.
- 2) A resolution to reaffirm and to continue to support the work of the National Pharmacy Insurance Council. Passed.
- 3) A resolution directing the Editor of *The Maryland Pharmacist* to devote more space describing upcoming convention activities in a special pre-convention issue. Passed.
- 4) A resolution requesting the APhA to send regular communications to local groups as well as state groups. Defeated.

Joseph U. Dorsch suggested that a committee be appointed to develop guidelines for the formation of any new local groups within an established local pharmaceutical association area.

Upon motion of Morris Bookoff, seconded by Richard D. Parker, it was recommended to the Board of Trustees of the MPhA that it consider a contribution to NPIC.

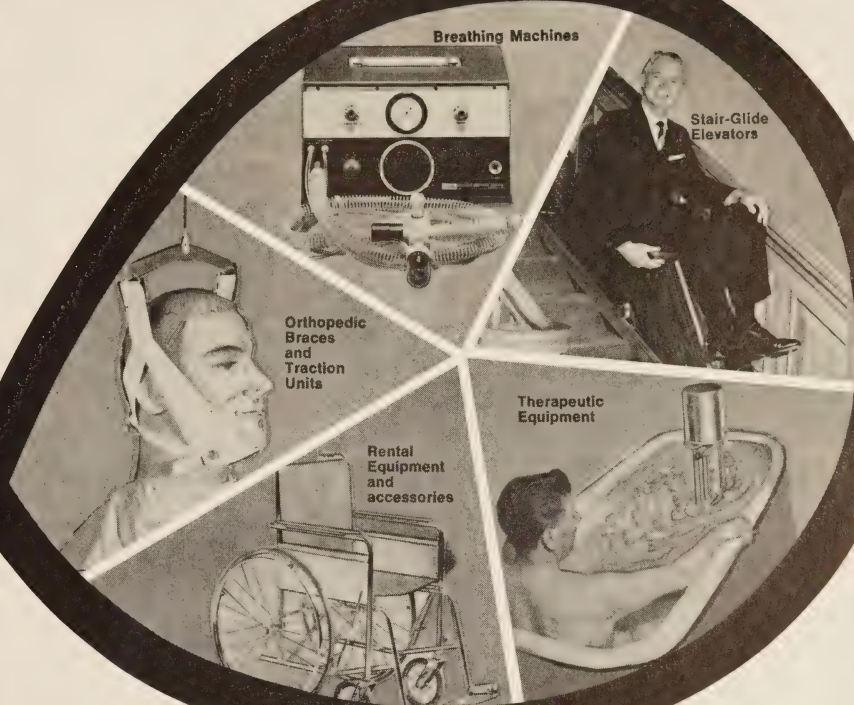
Samuel Morris suggested that PMA be requested to sponsor a public relations program for pharmacists.

M. Neal Jacobs suggested that the Association request the School of Pharmacy to conduct a study of the potential hazards involved in pharmacists inhaling antibiotic powder as well as a study to determine the feasibility of pharmacists being trained to take blood pressures and throat cultures.

Joseph U. Dorsch presented the Nominating Committee report. Recommendations to Governor Mandel for appointment for the term of Ralph Quarles on the Board of Pharmacy ending in 1974; Ralph Quarles, Robert E. Snyder, Harry Wille. Seconded by Morris Bookoff and approved.

Upon motion of Melvin J. Sollod, seconded by Nathan Schwartz, the presentation of the list of nominees for MPhA officers for 1974-1975 was postponed and upon further motion by Melvin J. Sollod, seconded by Nathan Schwartz, the incoming speaker of the House was in-

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structed to appoint a new nominating committee which is to present its report at the next session of the House of Delegates.

The Chair decided to accept that portion of the Nominating Committee report not dealing with officers for MPhA 1974-1975 term. Mr. Morgenroth appealed the decision of the Chair and the Speaker was sustained.

The nominations for Speaker of the House were as follows: Speaker: S. Ben Friedman; Vice Speaker: Robert E. Snyder. Alder Simon was nominated from the floor for the office of Speaker. S. Ben Friedman was elected Speaker. Alder Simon was nominated from the floor for the office of Vice Speaker. Alder Simon was elected Vice Speaker.

Melvin N. Rubin presented the Membership Committee report and the Prescription Insurance Plans Committee report. Paul Freiman presented the Legislative Committee report. He stated the agenda for the coming year included mandatory continuing education, amendment of the Drug Product Selection Law, Peer Review liability exemption, Board of Pharmacy residency requirement elimination, and OTC drugs.

Stephen Hospodavis presented the Professional Relations Committee report. Charles Spigelmire then presented the Public Relations Committee report. On motion of Mr. Morgenroth, Speaker Seidman was given a rising vote of thanks. This concluded the second session of the House of Delegates.

Morris Bookoff then reported on the Pharmaceutical Services Foundation. Closing remarks were made by President Lachman, who spoke of a group of pharmacists who come for the elections and left immediately, without interest in the Association business.

The session adjourned at 2:50 P.M.

New Members

The following is a list of the new members approved at the August 9, 1973 meeting of the Board of Trustees of the Maryland Pharmaceutical Association:

Paul Hiranka, Derwood, Maryland, Staff Pharmacist, NIH
Raymond Hollis, Takoma Park, Maryland, Dart Drug
Robert W. Holthaus, Millersville, Maryland, Beacon Pharmacy
Rudolph Paul Mierisch, Baltimore, Peoples
Tuong Anh Nguyen, Lutherville, Maryland General Hospital
Keith Rau, Silver Spring, Intern, North Dakota State University
Joseph M. Schuman, Edgewater, Edgewater Pharmacy
James Spear, Oxon Hill, Maryland
Ellen H. Yankellow, Baltimore, Good Samaritan Hospital
Martin L. Yankellow, Baltimore, Read's
Sidney M. Zalevsky, Silver Spring, Chief Pharmacist, Group Health Associates.

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NEW REGULATIONS

Methadone, Amphetamines and Methamphetamines

10.03.44 REGULATIONS GOVERNING THE PRESCRIBING AND DISPENSING OF METHADONE, AMPHETAMINES, AND METHAMPHETAMINES

Pursuant to the authority conferred by subsections (a-1), (a-2), and (b-1) of Section 285(a) and 285(b) of Article 27 of the Annotated Code of Maryland (1972 Cumulative Supplement) governing prescriptions required in certain instances, the following regulations governing the prescribing and dispensing of methadone, amphetamines, and methamphetamines are hereby established.

PREFACE

The Secretary of Health and Mental Hygiene recognizes that the public interest requires the control and curtailment of the illegal diversion and use of methadone, amphetamines, and methamphetamines. Therefore, in conjunction with the Medical and Chirurgical Faculty of Maryland, the Secretary hereby regulates the conditions under which persons may be treated by prescribing methadone, amphetamines, or methamphetamines.

.01 SCOPE

This regulation governs all persons legally authorized to prescribe or dispense drugs in the State of Maryland.

.02 DEFINITIONS

- A. *Prescriber*: A person authorized by law to practice medicine in the State of Maryland.
- B. *Dispenser*: A person authorized by law to practice medicine or pharmacy in the State of Maryland.
- C. *Methadone*: A synthetic, narcotic analgesic with multiple actions similar to those of morphine and other opioids or any drug that contains any quantity of methadone, its salts, its congeners, optical isomers and salts of optical isomers.
- D. *Amphetamines*: A synthetic stimulant to the central nervous system with an appetite reducing effect or any drug that contains any quantity of amphetamines, its salts, optical isomers, and salts of optical isomers.
- E. *Methamphetamines*: A drug related to amphetamines or any drug that contains any quantity of methamphetamine, its salts, optical isomers, and salts of optical isomers.

.03 RESTRICTIONS ON PRESCRIBING AND DISPENSING METHADONE

The prescribing and dispensing of methadone may take place under the following circumstances only:

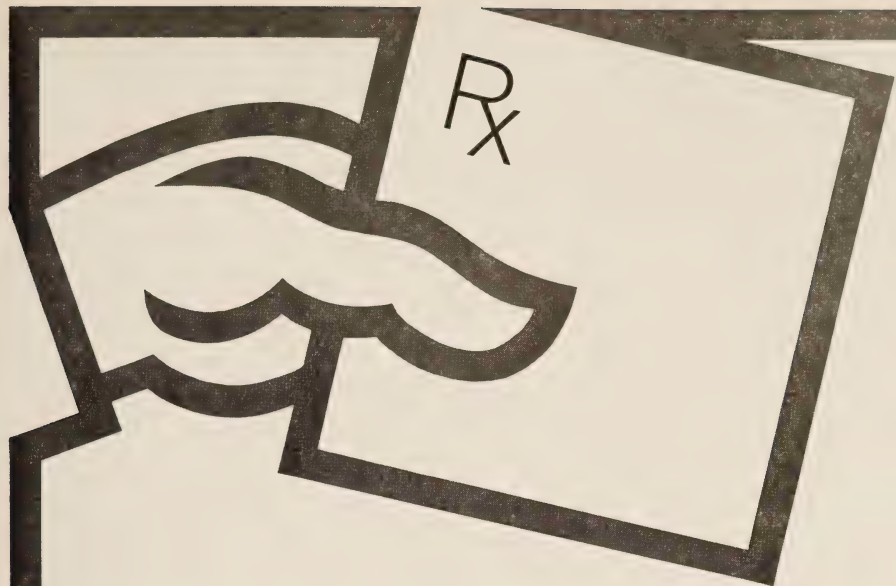
- A. Bona fide use of methadone for the patient with terminal disease with intractable pain. In such cases, the prescription blank may indicate the disease condition creating the problem. If such information is not on the prescription, the dispenser must obtain this information from the prescriber, and retain it in his records.

NOTE: In all cases, the dispenser must contact the prescriber for the purpose of ensuring the validity of the prescription and its use.

- B. For detoxification of the hospitalized drug dependent person, adequate documentary evidence must be in the hospital record indicating the necessity and reasons for the use of methadone for this purpose.
- C. In approved drug maintenance or detoxification programs authorized by the Drug Abuse Administration, Department of Health and Mental Hygiene.
- D. In Emergency Services of general hospitals as treatment of the withdrawal syndrome.
- E. For detoxification purposes by a prescriber, provided notification is sent to the Drug Abuse Administration of Maryland within 48 hours of the beginning of such activity. Such notification must be adequately supported by the medical or social reasons for the necessity of this activity being carried on outside the jurisdiction of an approved drug program. Forms for this purpose may be developed by the Drug Abuse Administration.
- F. For maintenance purposes by a prescriber in accordance with guidelines developed by the Drug Abuse Administration.
- G. In accordance with any changes that may be made by Federal regulations as published in the Federal Register.

.04 RESTRICTIONS ON PRESCRIBING AND DISPENSING AMPHETAMINES

- A. The prescribing and dispensing of amphetamines may take place only for the following conditions:
 - (1) Narcolepsy—patient shall be clearly diagnosed by physician as such; must be stated on patient record.
 - (2) Hyperkinesis—patient shall be clearly diagnosed by a physician as such; must be stated on patient record.
 - (3) In exceptional cases of obesity, which must be adequately documented, both initially and as to continuing need, the prescribing of amphetamines is permitted upon written notification to the Division of Drug Control, State Department of Health and Mental Hygiene within ten days of the initial prescription. The Division of Drug Control will refer those cases that should be further reviewed to the Medical and Chirurgical Faculty. Simple obesity does not call for the routine use of amphetamines to attain weight reduction.
 - (4) In selected, rare cases not listed above, the prescriber must be able to justify and docu-



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ment medical need by adequate medical records and notify the Division of Drug Control, State Department of Health and Mental Hygiene within ten days of the initial prescription. The Division of Drug Control will refer those cases that should be further reviewed to the Medical and Chirurgical Faculty.

- B. The prescribing and dispensing of parenteral amphetamines is prohibited.
- C. No more than a 34 day supply (quantity not to exceed 100 capsules or tablets or dosage units, whichever is less) of amphetamines shall be prescribed. This is in accordance with BNDD proposed regulations.

.05 REGULATION FOR RESTRICTIONS ON PRESCRIBING AND DISPENSING METHAMPHETAMINES

- A. Methamphetamine is a dangerous drug and subject to extreme abuse potential. It is recognized, however, that in selected cases its use may be necessary for the welfare of the patient. Under these circumstances, the prescriber of Methamphetamine must be able to justify and document medical need by adequate medical records and notify the Division of Drug Control, Department of Health and Mental Hygiene, within ten (10) days of the initial prescription. The Division of Drug Control will refer those cases that should be further reviewed to the Medical and Chirurgical Faculty.
- B. The Division of Drug Control, Department of Health and Mental Hygiene, may restrict the number of pharmacies which may stock Methamphetamine.
- C. No more than a 34 day supply (quantity not to exceed 100 capsules or tablets or dosage units, whichever is less) of Methamphetamine shall be prescribed. This is in accordance with BNDD proposed regulation.

.06 SEVERABILITY

If any clause, sentence, paragraph, section or part of this regulation shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section of part thereof directly involved in the controversy in which such judgment shall have been rendered.

Adopted: July 31, 1973

Effective: August 7, 1973

NEIL SOLOMON, M.D., PH.D.

*Secretary of The
Maryland State Department of Health
and Mental Hygiene*

Maryland Board of Pharmacy News

Pharmacy Changes

The following are the pharmacy changes for the month of September:

New Pharmacies

Tidewater Pharmacy, Inc., Walter S. Szot, Jr., President; Box 208, Mechanicsville, Maryland 20659.

No Longer Operating As Pharmacies

Drug Fair No. 52, Milton L. Elsberg, President; 2451 Chillum Road, Hyattsville, Maryland 20782.

John R. Thomas, Pharmacist; John R. Thomas, 6712 Holabird Avenue, Baltimore, Maryland 21222.

Changes of Ownership, Address

MEMCO Prescription Pharmacy No. 361, Wayne H. Fisher, Jr., President (Change of corporate structure); 5505 Allentown Road, Camp Springs, Maryland 20023.

MEMCO Prescription Pharmacy No. 364, Wayne H. Fisher, Jr., President; (Change of corporate structure); 6411 Riggs Road, Hyattsville, Maryland 20783.

MEMCO Prescription Pharmacy No. 365, Wayne H. Fisher, Jr., President; (Change of corporate structure); 12250 Rockville Pike, Rockville, Maryland 20805.

Forest Glen Medical Pharmacy, Adlai M. Hendrix (Change of pharmacy name and ownership), 9801 Georgia Avenue, Silver Spring, Maryland 20902.

Mount Rainier Pharmacy, Mary R. Latona, President (Change of ownership); 4006 - 34th Street, Mount Rainier, Maryland 20822.

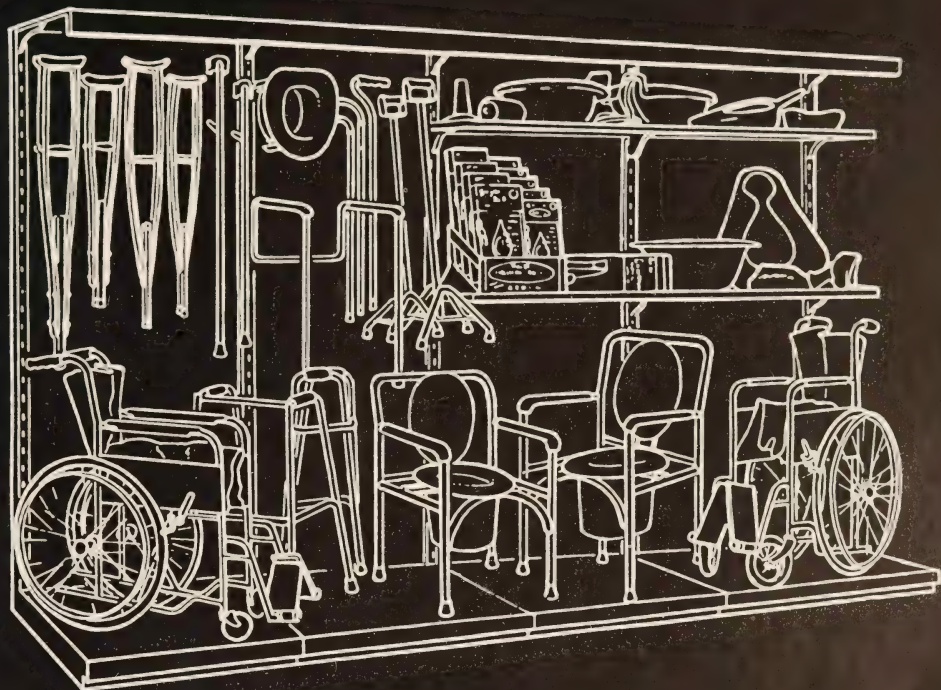
Myers Drug Store, Mary L. Myers (Change of ownership), 100 South Main Street, Mount Airy, Maryland 21771.

Maryland Society of Hospital Pharmacists

The September 14 meeting of the Maryland Society of Hospital Pharmacists was held at the Johns Hopkins Hospital. The guest speaker was Delegate Torrey C. Brown, M.D. Dr. Brown spoke on the Maryland State Formulary.

The business session was conducted by President Thomas E. Patrick. Arthur Riley, General Chairman of the 1974 Seminar, announced that the 1974 Seminar Committee would include Henry J. Derewicz, G. Lawrence Hogue, John Mentzer, Thomas E. Patrick, Ronald Telak and Harry Hamet.

Normand Pelissier reported on the Board of Directors meeting held on September 13 to discuss the Model Institutional Pharmacy Law. Henry Derewicz will chair the Institutional Pharmacy Practice Committee formed by the Board. President Patrick presented the E. R. Squibb Past President's Award to Normand Pelissier.



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There are 20 million Americans age 65 or older—plus physically impaired or convalescents of all ages—many of whom require home health care aids. (It is estimated that annual volume is double that of prescriptions.) Medicare has greatly expanded the demand for home health care aids from a dependable local source in every community—a source such as your pharmacy.

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University of Maryland

School of Pharmacy

Two University of Maryland School of Pharmacy students were accepted for internship with the National Coordinating Council on Drug Education in Washington, D.C. as part of NCCDE's ongoing efforts to provide meaningful policy analysis for its pharmacy member associations. Janet Jones of Camp Springs, Md. and Walter Dolan of Baltimore will investigate drug related developments in both houses of Congress and the Department of Health, Education and Welfare (HEW) for *National Drug Reporter*, the twice-monthly periodical of the Coordinating Council.

NCCDE is the oldest and largest private non-profit membership organization active in the fields of drug abuse education and prevention. The Council's many ongoing projects are supported by more than 140 active members, including the American Association of Colleges of Pharmacy (AACP), American Pharmaceutical Association (APhA), National Association of Chain Drug Stores (NACDS), National Association of Pharmaceutical Manufacturers (NAPM), National Council of State Pharmaceutical Association Executives (NCSPA), National Wholesale Druggists Association, Pharmaceutical Manufacturers Association, the Proprietary Association, and the Student American Pharmaceutical Association. MPhA Executive Director Nathan I. Gruz is the representative of NCSPA.

Ms. Jones and Mr. Dolan are "externs" in the U. of Maryland Pharmacy School's Pharmacy Experience Program (PEP), in which pharmacy students spend portions of their senior year working in pharmacy-related organizations.

A. G. DuMez Memorial Lecture

The Sixth Annual A. G. DuMez Memorial Lecture was presented by the University of Maryland School of Pharmacy on October 10 at 1 p.m. The visiting lecturer for the special occasion was Dr. Jan Koch-Weser, Associate Professor of Pharmacology at the Harvard Medical School and Chief of the Clinical Pharmacology Unit at Massachusetts General Hospital, Boston, Massachusetts. His theme was "Drug Interactions in Clinical Practice."

Dr. Koch-Weser serves on the Food and Drug Administration's Drug Experience Advisory Committee, on the Council on Basic Science, on the Science Advisory Board of the American Heart Association, on the Pharmacology and Toxicology Review Committee and Progress Committee of Pan Am Health Organization, and is a member of the National Institute of General Medical Science of the National Institutes of Health.

The lecture commemorates the late Dr. A. G. DuMez, Dean of the University of Maryland School of Pharmacy

from 1926 to 1948. An outstanding national and international educator and leader in pharmacy, he helped raise the standards for pharmaceutical education and was instrumental in establishing graduate studies at the University of Maryland School of Pharmacy. Dr. DuMez is a past recipient of the highest national pharmacy award, the Remington Medal.

Continuing Education

A Seminar on the Pharmacist as a Consultant to Hospitals, Nursing Homes, and Extended Care Facilities was presented on September 21 and 22 at the Center for Adult Education, College Park, Maryland. The program provided information and knowledge to administrators, directors and nursing personnel of these facilities.

Additional programs for the winter and spring schedule will include two 8-week evening programs, and a one-day antibiotic course to be delivered at three different areas of the state. Also available is an independent study offering of five cassette tape courses which include, (1) Selected Topics in Pharmacology, (2) Over-The-Counter Preparations-Dermatologicals, (3) Clinical Drug Interactions, (4) Pharmacologic Approaches to Disease States, and (5) Introductory Aspects of Clinical Pharmacy. The courses consisting of either 7 or 8 lectures—2 hours each—may be purchased in a complete unit supplemented with a lecture guide and a check test. A descriptive brochure will be sent on request. Inquiries may be directed to Henry G. Seidman, Director of Continuing Education, University of Maryland School of Pharmacy, 636 W. Lombard Street, Baltimore, Maryland 21201.

University of Maryland School of Pharmacy Alumni Association

The Second Annual Oyster Roast of the University of Maryland School of Pharmacy Alumni Association will be held on Sunday, January 27. The affair which will benefit the Francis S. Balassone Memorial Lecture Fund will be held at Overlea Caterers, 6809 Bel Air Road from 1 to 6 p.m. An excellent menu is planned which will feature raw oysters on the half shell, oyster fritters, barbecued spareribs, baked ham, cole slaw, rolls, bread and butter, oyster stew, sliced top round of beef, knockwurst, sauerkraut, potato salad, relishes, cheeses, coffee, and assorted sweets.

In addition there will be games of chance, prizes, music for your listening pleasure and dancing. For more information please contact Mr. Henry G. Seidman at the School of Pharmacy.

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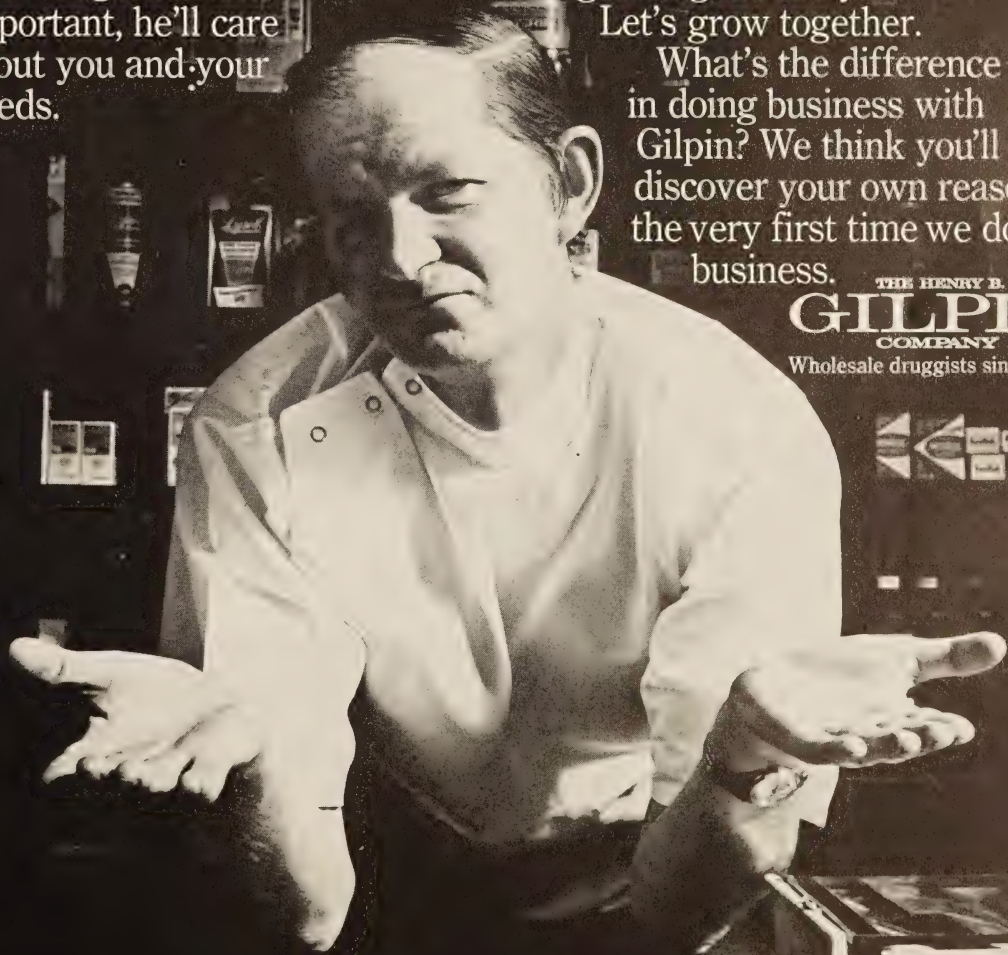
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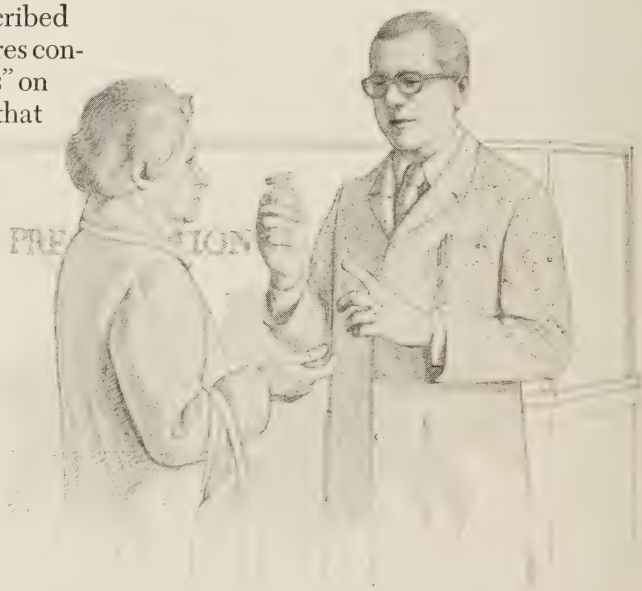
Wide clinical experience has shown that, in properly selected patients, levodopa is the most effective agent for relief of symptoms of Parkinson's disease and syndrome, and that Larodopa (levodopa) is the brand of levodopa most widely preferred by physicians. Only Larodopa is available in tablet as well as capsule form. Its wide range of dosage options permits you to meet the varying requirements of most levodopa prescriptions without a large inventory of different brands.

As the most frequently prescribed brand of levodopa, Larodopa assures constant turnover and seldom "expires" on the shelf. Physicians are informed that Roche has the widest pharmacy distribution of all levodopa products and, as leader in the market, has a continuing commitment to levodopa promotion and research.

Larodopa offers consistently high quality—and only Larodopa provides the Roche-patented tablet form of levodopa. The scored, easily divided tablet makes it possible to use a single-strength tablet to vary

the dose as needed. This is both more convenient and less confusing for the patient, as it eliminates the need for multiple prescriptions for capsules of differing strengths.

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Before prescribing, please consult complete product information, a summary of which follows:

In order to reduce the high incidence of adverse reactions, it is necessary to individualize the therapy and to gradually increase the dosage to the desired therapeutic level.

Indications: For the treatment of idiopathic Parkinson's disease (paralysis agitans), postencephalitic parkinsonism, manganese intoxication, symptomatic parkinsonism due to carbon monoxide intoxication, and parkinsonism in the elderly associated with cerebral arteriosclerosis.

Contraindications: In patients receiving MAO inhibitors (the latter must be discontinued two weeks prior to initiating therapy with Larodopa); in narrow angle glaucoma; and in patients with known hypersensitivity to levodopa.

Warnings: Administer cautiously to patients with severe cardiovascular or pulmonary disease, bronchial asthma, renal, hepatic or endocrine disease. Administer with care and in a facility with a coronary care unit or intensive care unit to patients with myocardial infarction who have residual atrial, nodal or ventricular arrhythmias. Be alert to possibility of upper gastrointestinal hemorrhage in patients with a history of active peptic ulcer disease. Monitor carefully all patients for development of depression with concomitant suicidal tendencies. Treat psychotic patients with caution.

Oral doses of 10 to 25 mg of pyridoxine hydrochloride (vitamin B₆) rapidly reverse the toxic and therapeutic effects of Larodopa (levodopa). Therefore, carefully consider concomitant administration of the two agents. In pregnancy, weigh potential benefits against possible hazards. Do not use in nursing mothers. Safety of Larodopa in children under age 12 not established.

Precautions: Periodic evaluations of hepatic, hematopoietic, cardiovascular and renal function recommended during extended therapy in all patients. Patients with chronic wide angle glaucoma may be treated cautiously provided intraocular pressure is well controlled and monitored carefully during therapy. To patients on an antihypertensive drug, administer carefully, adjusting dosage if necessary. For patients receiving pargyline, see note on MAO inhibitors contraindications.

Adverse Reactions: *Most serious*—occurring most frequently: adventitious movements (e.g., choreiform and/or dystonic); *most serious*—occurring less frequently: cardiac irregularities and/or palpitations, orthostatic hypotensive episodes, brady-

kinetic episodes (the "on-off" phenomena), mental changes including paranoid ideation and psychotic episodes, depression with or without the development of suicidal tendencies, dementia, and urinary retention; *most serious*—occurring rarely: gastrointestinal bleeding, development of duodenal ulcer, hypertension, phlebitis, hemolytic anemia, agranulocytosis, and convulsions. (The causal relationship between convulsions and Larodopa has not been established.)

Less serious—occurring relatively frequently: anorexia, nausea and vomiting with or without abdominal pain and distress, dry mouth, dysphagia, sialorrhea, ataxia, increased hand tremor, headache, dizziness, numbness, weakness and faintness, bruxism, confusion, insomnia, nightmares, hallucinations and delusions, agitation and anxiety, malaise, fatigue and euphoria; *less serious*—occurring less frequently: muscle twitching and blepharospasm (which may be taken as an early sign of overdosage; consideration of dosage reduction may be made at this time), trismus, burning sensation of the tongue, bitter taste, diarrhea, constipation, flatulence, flushing, skin rash, increased sweating, bizarre breathing patterns, urinary incontinence, diplopia, blurred vision, dilated pupils, hot flashes, weight gain or loss, dark sweat and/or urine; *less serious*—occurring rarely: oculogyric crises, sense of stimulation, hiccups, development of edema, loss of hair, hoarseness, priapism and activation of latent Horner's syndrome.

The following have been noted: elevations of BUN, SGOT, SGPT, LDH, bilirubin, alkaline phosphatase or PBI; occasionally, reductions in WBC, hemoglobin and hematocrit; elevations of uric acid with use of colorimetric method but not with uricase; occasionally, positive Coombs test; leukopenia, requiring at least temporary discontinuance of Larodopa (levodopa).

Dosage and Administration: Because of the necessity for individualizing therapy, the usual optimal therapeutic dosage should not exceed 8 Gm, and should be carefully titrated for each individual patient. The physician should thoroughly familiarize himself with the information in the package insert before instituting therapy.

How Supplied: *Tablets*, pink, scored, containing 0.1 Gm levodopa (imprinted ROCHE 72), bottles of 100; containing 0.25 Gm levodopa (imprinted ROCHE 57) or 0.5 Gm levodopa (imprinted ROCHE 56)—bottles of 100 and 500.

Capsules, containing 0.25 Gm levodopa (pink and beige, imprinted ROCHE 55) or 0.5 Gm levodopa (pink, imprinted ROCHE 54)—bottles of 100 and 500.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Prescription Insurance Programs

THIRD PARTY PLANS

August, 1973

The following is a compilation prepared by Melvin Rubin and Jerome Mask of "Third Party Plans" listing most of the prescription programs currently offered in Maryland. If you receive any prescriptions for a plan not included, please advise the MPhA Office. Additional data sheets for new plans, as well as notices of any changes or revisions will be issued.

PLAN: BLUE CROSS STANDARD/BLUE CROSS MOTORS

PHARMACY NO.
(ASSIGNED BY PLAN)
ADMINISTRATOR:
Maryland Blue Cross
ADDRESS:
700 E. Joppa Rd., Baltimore, Md. 21204
TELEPHONE:
Claims: 494-5880; Pharmacy Representative: 494-5397
BASIS OF COST:
Acquisition
FEE:
\$1.95
DEDUCTIBLE:
None to \$2.00 as indicated on I.D. card.
PRESCRIPTIONS COVERED:
Federal Law: Yes; State Law: Standard—Yes, Motors—
No; Local Law: No.

O.T.C. DRUGS:

No

BIRTH CONTROL:

As indicated on I.D. card.

INSULIN:

Up to 4 vials per Rx. Usual charge.

REFILLS ALLOWED:

1 year.

LIMITS:

34 days supply or 100 unit doses per list in Blue Cross Manual for drugs for "chronic conditions."

INFO REQUIRED ON PAYMENT FORM:

Information on I.D. card including group number, pharmacy member number, date of filling, relationship of patient to card holder. Circle either "I," "C," or "L."

MISCELLANEOUS INFO:

Pays weekly. Card does not list expiration date. Dependent eligibility until Dec. 31 of year maximum age is reached.

PLAN: ESSKAY

PHARMACY NO.
(ASSIGNED BY PLAN)
ADMINISTRATOR:
Maryland Pharmaceutical Association
ADDRESS:
650 W. Lombard St., Baltimore, Md. 21201
TELEPHONE:
727-0746
BASIS OF COST:
Average Wholesale Price
FEE:
\$1.95
DEDUCTIBLE:
50 cents
PRESCRIPTIONS COVERED:
Federal Law: Yes; State Law: No; Local Law: No.

O.T.C. DRUGS:

No

BIRTH CONTROL:

No

INSULIN:

Must be on Rx blank. Cost plus 50%.

REFILLS ALLOWED:

Indicated by physician.

LIMITS:

Not specified.

INFO REQUIRED ON PAYMENT FORM:

Information on I.D. card.

MISCELLANEOUS INFO:

Forms available from Maryland Pharmaceutical Association office. Nominal processing fee—member—15c; non-member—25c.

PLAN: MEDICAID

PHARMACY NO.
(ASSIGNED BY PLAN)
ADMINISTRATOR:
State of Maryland

ADDRESS:

301 W. Preston St., Baltimore, Md. 21201

TELEPHONE:

General: 383-2827; Preauthorization: Baltimore City — 396-4620, Baltimore County—484-2727, Howard County—465-5000; others listed in State booklet.

BASIS OF COST:

Average Wholesale Price

FEE:

\$1.75

DEDUCTIBLE:

None

PRESCRIPTIONS COVERED:

Federal Law: Yes; State Law: Yes; Local Law: Yes.

O.T.C. DRUGS:

Must be on Rx blank. AWP + 50% or usual price if lower; \$1.00 minimum.

BIRTH CONTROL:

Yes

INSULIN:

Must be on Medicaid blank. Usual selling price. Up to 90 day supply. Needles and syringes on Medicaid blank—Up to \$5.00 retail.

REFILLS ALLOWED:

2 within 90 days. Must be specified on original Rx. No refills on antibiotics.

LIMITS:

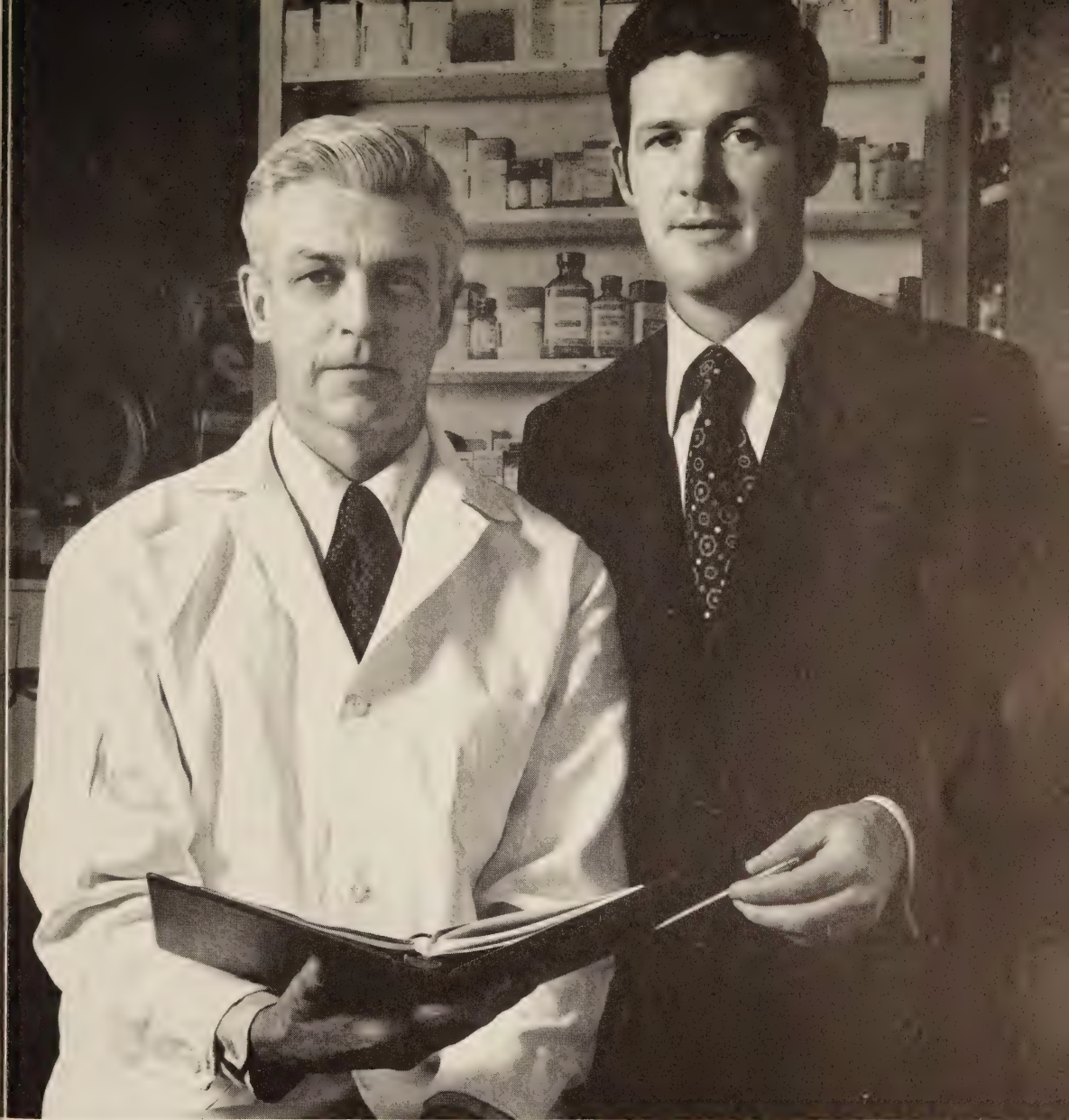
\$10.00 maximum cost of drug. Antibiotics—10 day supply. Over the above limits must be preauthorized. Must give diagnosis for preauthorization of antibiotic for more than 10 days.

INFO REQUIRED ON PAYMENT FORM:

Information on I.D. card including eligibility dates. Original date on refills. Indicate which refill, No. 1 or No. 2. NDC number of drug.

MISCELLANEOUS INFO:

Each eligible member has separate card. First 2 digits indicate subdivision of residence. Only one Rx per each blank. Refill forms supplied by local subdivision of State.



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party-pay programs. Or what's happening with Health Maintenance Organizations.

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C I B A

PLAN: N.M.U. WELFARE PLAN

PHARMACY NO.
(ASSIGNED BY PLAN)

ADMINISTRATOR:
Prescription Plan Service, Inc.

ADDRESS:
126 University Place, New York, N.Y. 10003

TELEPHONE:
1-212-243-7730

BASIS OF COST:
Average Wholesale Price

FEE:
\$2.00

DEDUCTIBLE:
\$2.00

PRESCRIPTIONS COVERED:
Federal Law: Yes; State Law: Yes; Local Law: Yes.

O.T.C. DRUGS:
Must be on Rx blank.

BIRTH CONTROL:
Yes

INSULIN:
Must be on Rx. Cost plus 50%.

REFILLS ALLOWED:
One. Only if authorized on original Rx.

LIMITS:
34 day supply or 100 unit doses of select list supplied by N.M.U. \$20.00 maximum unless preauthorized.

INFO REQUIRED ON PAYMENT FORM:
Information on I.D. card.

MISCELLANEOUS INFO:
Forms supplied to patient for MD to write Rx. MD may phone in Rx if signed form follows. If proper form not available may send original or photocopy of Rx.

PLAN: PAID PRESCRIPTIONS

PHARMACY NO.
(ASSIGNED BY PLAN)

ADMINISTRATOR:
Paid Prescriptions

ADDRESS:
Box 418, Clifton, N.J. 07015

TELEPHONE:
1-201-773-7005

BASIS OF COST:
Plan No. 1: Average Wholesale Price; Plan No. 2: Acquisition.

FEE:
Refer to PAID manual—\$1.85 to \$2.20.

DEDUCTIBLE:
Up to \$2.00 as indicated on I.D. card.

PRESCRIPTIONS COVERED:
Federal Law: Yes; State Law: Some plans—refer to PAID manual. Local Law: No.

O.T.C. DRUGS:
No

BIRTH CONTROL:
No

INSULIN:
One vial per Rx. Cost plus 50%.

REFILLS ALLOWED:
Local No. 99—6 mos. For others refer to PAID manual. 34 day supply or 100 units as indicated in PAID manual.

INFO REQUIRED ON PAYMENT FORM:
Information on I.D. card, pharmacy number, name of patient, age of patient, NDC number of drug.

MISCELLANEOUS INFO:
Enrollment Fee: \$15.00. No renewal fee. Imprinter Fee: \$10.00. Fee deducted from invoices after first \$100.00 business.

PLAN: PHARMACEUTICAL CARD SYSTEM (PCS)

PHARMACY NO.
(ASSIGNED BY PLAN)

ADMINISTRATOR:
Pharmaceutical Card System

ADDRESS:
P.O. Box 20831, Phoenix, Ariz. 85036

TELEPHONE:
1-602-244-9766

BASIS OF COST:
Refer to PCS manual.

FEE:
Refer to PCS manual.

DEDUCTIBLE:
Up to \$2.00 as indicated on I.D. card.

PRESCRIPTIONS COVERED:
Federal Law: Yes; State Law: Refer to PCS manual; Local Law: Refer to PCS manual.

O.T.C. DRUGS:
Refer to PCS manual.

BIRTH CONTROL:
Refer to PCS manual.

INSULIN:
Most plans one vial per Rx. Cost plus 50%. Refer to PCS manual.

REFILLS ALLOWED:
1 year

LIMITS:
Refer to PCS manual.

INFO REQUIRED ON PAYMENT FORM:
Information on I.D. card (must use plastic card and imprinter). Must use PCS code for drug (in manual).

MISCELLANEOUS INFO:
Enrollment Fee: \$10.00. Yearly renewal fee: \$8.00 if more than 30 claims were processed. \$40.00 for imprinter if needed. Fee taken off invoices. No advance payment.

PLAN: Rx PRESCRIPTION PLAN

PHARMACY NO.
(ASSIGNED BY PLAN)

ADMINISTRATOR:
1199 Benefit Fund

ADDRESS:
310 W. 43rd St., New York, N.Y. 10036

TELEPHONE:
1-212-582-1890

BASIS OF COST:
Average Wholesale Price

FEE:
\$2.00

DEDUCTIBLE:
None

PRESCRIPTIONS COVERED:
Federal Law: Yes; State Law: No; Local Law: No.

O.T.C. DRUGS:
No

BIRTH CONTROL:
No

INSULIN:
Cost plus 50%.

REFILLS ALLOWED:
Up to 5 in 6 months if authorized by MD on original 10 day supply. Specified list of maintenance drugs 34 days or 100 unit doses. Preauthorization needed for over \$50.00.

INFO REQUIRED ON PAYMENT FORM:
Fill in all information called for on payment blank.

MISCELLANEOUS INFO:
Forms supplied to patient for MD to write Rx. MD may phone in original. Send photocopy of Rx if written on MD Rx blank and plan form onto which the prescription is copied. Dependents eligible to age 19.

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PLAN: PRESCRIPTION DRUGS, INC. (PDI)

PHARMACY NO.
(ASSIGNED BY PLAN)

ADMINISTRATOR:
Prescription Drugs, Inc.

ADDRESS:
9008 Red Branch Rd., Oakland Ridge, Industrial Park,
Columbia, Md. 21045

TELEPHONE:
997-3550 997-3551

BASIS OF COST:
Average Wholesale Price.

FEE:
\$1.85

DEDUCTIBLE:
Up to 75c as indicated on I.D. card.

PRESCRIPTIONS COVERED:
Federal Law: Yes; State Law: No; Local Law: No.

O.T.C. DRUGS:
No

BIRTH CONTROL:
Yes. Cost plus fee.

INSULIN:
One vial per Rx. Cost plus fee.

REFILLS ALLOWED:
As per MD indication.

LIMITS:
34 day supply or 100 unit doses for "chronic conditions." No specified list.

INFO REQUIRED ON PAYMENT FORM:
Information on I.D. card, NDC number of drug.

PLAN: SINAI HOSPITAL PROGRAM FOR NON-UNION EMPLOYEES

PHARMACY NO.
(ASSIGNED BY PLAN)

ADMINISTRATOR:
Pharmaceutical Services Foundation of Maryland, Inc.

ADDRESS:
650 W. Lombard St., Baltimore, Md. 21201

TELEPHONE:
539-5415

BASIS OF COST:
Average Wholesale Price

FEE:
\$2.00

DEDUCTIBLE:
None

PRESCRIPTIONS COVERED:
Federal Law: Yes; State Law: Yes; Local Law: No.

O.T.C. DRUGS:
No

BIRTH CONTROL:
No

INSULIN:
Cost plus 50%.

REFILLS ALLOWED:
Up to 5 as indicated by MD within one year.

LIMITS:
34 day supply or 100 unit doses for "chronic conditions." No specified list. Antibiotics: 40 capsules or tablets per Rx. Quantity of 100 allowed for chronic use if diagnosis supplied. Ointment/Creams: 4-oz. per Rx.

INFO REQUIRED ON PAYMENT FORM:
Information on I.D. card.

MISCELLANEOUS INFO:
Form same as Esskay. Must maintain patient record. Patient pays non-participating pharmacy for Rx. Has pharmacy fill out receipt showing patient, MD, transcript of Rx, charge. Takes receipt back to Sinai, receives 75% reimbursement from Pharmaceutical Services Foundation. Fee to participate: information available from Pharmaceutical Services Foundation. Dependent eligible to age 19 unless full time student, then age 23.

PLAN: UNION PRESCRIPTION PLAN (UPP)

PHARMACY NO.
(ASSIGNED BY PLAN)

ADMINISTRATOR:
Tolly International of Pennsylvania, Inc.

ADDRESS:
Public Ledger Building, Independence Square,
Philadelphia, Pa. 19166

TELEPHONE:
Funds 3 and 625: 837-9600; Fund 19: 1-215-WA. 3-7300;
Fund 1: 563-2500; Forms: 563-2500.

BASIS OF COST:
Acquisition

FEE:
\$1.85

DEDUCTIBLE:
50 cents

PRESCRIPTIONS COVERED:
Federal Law: Yes; State Law: Yes; Local Law: Yes.

O.T.C. DRUGS:
Selected list available from UPP. Must be prescribed on Rx blank.

BIRTH CONTROL:
Fund 3 (Local 692 and 400), Fund 4, Fund 10, Fund 13 at cost plus 50%.

INSULIN:
Must be on Rx. Cost plus 50%.

REFILLS ALLOWED:
One year

LIMITS:
100 day supply unless cost of 14 day supply is more than \$15.00, then only 14 days supply at one time.

INFO REQUIRED ON PAYMENT FORM:
Information on I.D. card, including group number, pharmacy number, date of filling, original date on refills, name of patient, relationship to card holder, NDC number of drug.

MISCELLANEOUS INFO:
Pays twice monthly. Prescriptions more than 5 months old will not be paid. All claims for unpaid prescriptions must be submitted within 90 days after receipt.

PLAN: WAREHOUSE EMPLOYEES LOCAL No. 570

PHARMACY NO.
(ASSIGNED BY PLAN)

ADMINISTRATOR:
Warehouse Employees Local No. 570

ADDRESS:
2219 St. Paul St., Baltimore, Md. 21218

TELEPHONE:
235-2353

BASIS OF COST:
Average Wholesale Price

FEE:
Non-compounded: \$1.85. Compounded: \$2.85.

DEDUCTIBLE:
50 cents

PRESCRIPTIONS COVERED:
Federal Law: Yes; State Law: Yes; Local Law: No.

O.T.C. DRUGS:
No

BIRTH CONTROL:
No

INSULIN:
Cost plus 50%.

REFILLS ALLOWED:
One year

LIMITS:
34 day supply or 100 unit doses for "chronic conditions." No specified list.

INFO REQUIRED ON PAYMENT FORM:
Information on I.D. card.

MISCELLANEOUS INFO:
Word "Drug" must be embossed on I.D. card to show drugs are covered. Use only one prescription per form. Dependents eligible to age 19.

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Washington Spotlight For Pharmacists

By

APhA Legal Division

FDA Recall Policy

Alexander M. Schmidt, M.D., Commissioner of Food and Drugs, has recently issued a statement regarding FDA policy for the recall of drugs, medical devices, and foods. Commissioner Schmidt noted FDA's principal legal authority to remove products from the market is seizure; the Food, Drug and Cosmetic Act does not mention recall procedures as a part of FDA's statutory authority. Recall procedures, although without clear statutory authority, generally allow for a more speedy retrieval, according to Commissioner Schmidt.

Among the primary changes in FDA recall policy is that the nature of the hazard from a defective product will be more precisely defined. Recalls will be divided into three major classes. Class I recalls are those presenting the most serious threat to health such as botulinum toxin in foods or a label mixup of a potent drug. Class II recalls involve less imminent dangers where the hazard is only potential. An example of a Class II recall would be the recall of a subpotent drug used for conditions that are not life threatening. Class III recalls involve violations of the law where the health hazard is nonexistent or remote. An adulterated food or drug may be included as a Class III recall.

The FDA has also modified its prior policy of issuing a national press release for every recall that presents hazard to health. The only change, according to the Commissioner, is that, in certain instances, the FDA will seek to limit the degree of publicity when recalling a particular product. As an example of a situation appropriate for limited publicity, the Commissioner stated:

Suppose that a defective heart-lung machine is distributed to 50 hospital operating rooms. The manufacturer can identify all 50 of the hospitals. A telegram or personal visit by the FDA or by the product manufacturer to those hospitals would promptly and adequately notify the affected public and assure that corrective action is taken. Further, such notice would minimize unnecessary confusion in the thousands of hospitals where similar machines, not involved in the recall, may be in use.

In addition, Commissioner Schmidt noted that, in the case of a recall of life saving or life supporting products such as pacemakers, FDA will, whenever possible, identify the patients using the defective device and notify the patient's physician.

Study Challenges Link Between Drug Use And Crime

The increased incidence of crime and the proliferation of drug misuse and drug addiction during the past decade has inspired many estimates of a correlation between them. The implications of such a correlation have affected national policy, state and local laws, and police tactics. The National Commission on Marihuana and Drug Abuse has earlier noted as incorrect the popular belief that some drugs diminish or destroy the individual's capacity to control his own behavior. Further, the Commission states, "Any perceived correlation between use of the drug and the unwanted consequence is attributed to the drug, removing the individual from any and all responsibility."

The Bureau of Narcotics and Dangerous Drugs (now the Drug Enforcement Administration) funded a major research study to investigate this possibility of a relationship between the increase in criminal activity and the sharp rise in the illicit use of drugs. In particular, the study was to determine whether the increased use of illicit drugs has caused a shift over the last few years from minor property crimes or forms of commercialized vice to more serious crimes such as crimes involving personal violence.

The researchers found that, when analyzing arrest charges for drug users versus nondrug users, there was no indication that drug users are more often involved in crimes of violence, such as homicide, rape, kidnapping, or assault than were nondrug users. In fact, when considering the major classifications of drugs subject to misuse, the distribution of arrest charges for drug users and non-users was either essentially the same or significantly different in that drug users were involved less frequently in crimes of violence. However, for the illicit user of narcotics and to a lesser extent other types of drugs, there is a higher proportion of cases involving potential financial gain such as robbery or larceny.

Because of the apparent misconception between drug misuse and violent crime, the National Commission on Marihuana and Drug Abuse has stated that the institutional response to the drug problem has often been more reflexive than rational. Accordingly, legislators and other policy makers should find this research on the correlation between crime and drug abuse useful when considering the appropriate goals toward which drug policy should be directed.

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In The News . . .

MSHP member JOSEPH T. STASNY, Chief of Pharmacy Service at the Perry Point VA Hospital, was recently awarded the title of Able Toastmaster (ATM) by Toastmasters International. HARRY HAMET was recently promoted to Assistant Director of Pharmacy at the Johns Hopkins Hospital. Mr. Hamet currently serves as MSHP Treasurer.

Hypertension Screening by the Pharmacist

The National High Blood Pressure Education Program was mounted as the prevalence of hypertension as a major health problem became evident. An estimated 23 million Americans suffer from the disease, and half of those are unaware of it. The important role the pharmacist can play in public education, hypertensive screening and in monitoring and follow-through on treated patients is now being recognized. At least one community pharmacist in the Baltimore area now offers his patients blood pressure testing at no charge. The APhA Academy of General Practice believes that pharmacists can play an important role in this area and they will indeed be called upon to do so.

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Obituaries

William Chester Shoemaker

William Chester Shoemaker, 72, a 1921 graduate of the University of Maryland School of Pharmacy, died on September 11. Mr. Shoemaker was head of food operations for Read's Drug Stores and a past Vice President of the School of Pharmacy Alumni Association.

Joseph LeGrand Johnson, Sr.

Joseph LeGrand Johnson, Sr., 82, died on September 10. A former member of the Maryland Pharmaceutical Association, Johnson's son and grandson, Joseph L. Jr., and Joseph L. III, are both pharmacists.

Clifford A. Hare

Clifford A. Hare, 60, a 1934 graduate of the University of Maryland School of Pharmacy, died on September 17. He was a member of the Maryland Pharmaceutical Association and former proprietor of the Kinamon and Briele Pharmacy.

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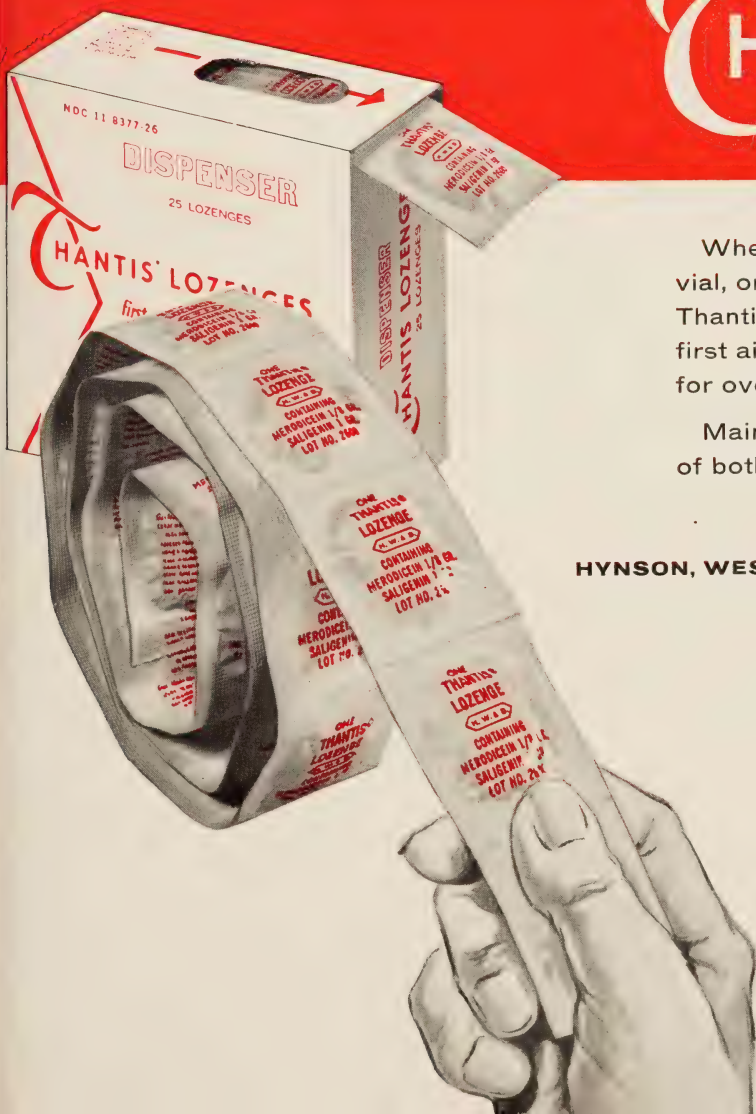
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the maryland pharmacist

OCTOBER

1973

Volume 49

Number 10

Editorial—

*Public Relations Imagery . . . or
Health Service to the Public?*

MPhA — LAMPA — TAMPA

Fall Regional Meeting Reports

URGENT!

OSHA Requirements for Employers

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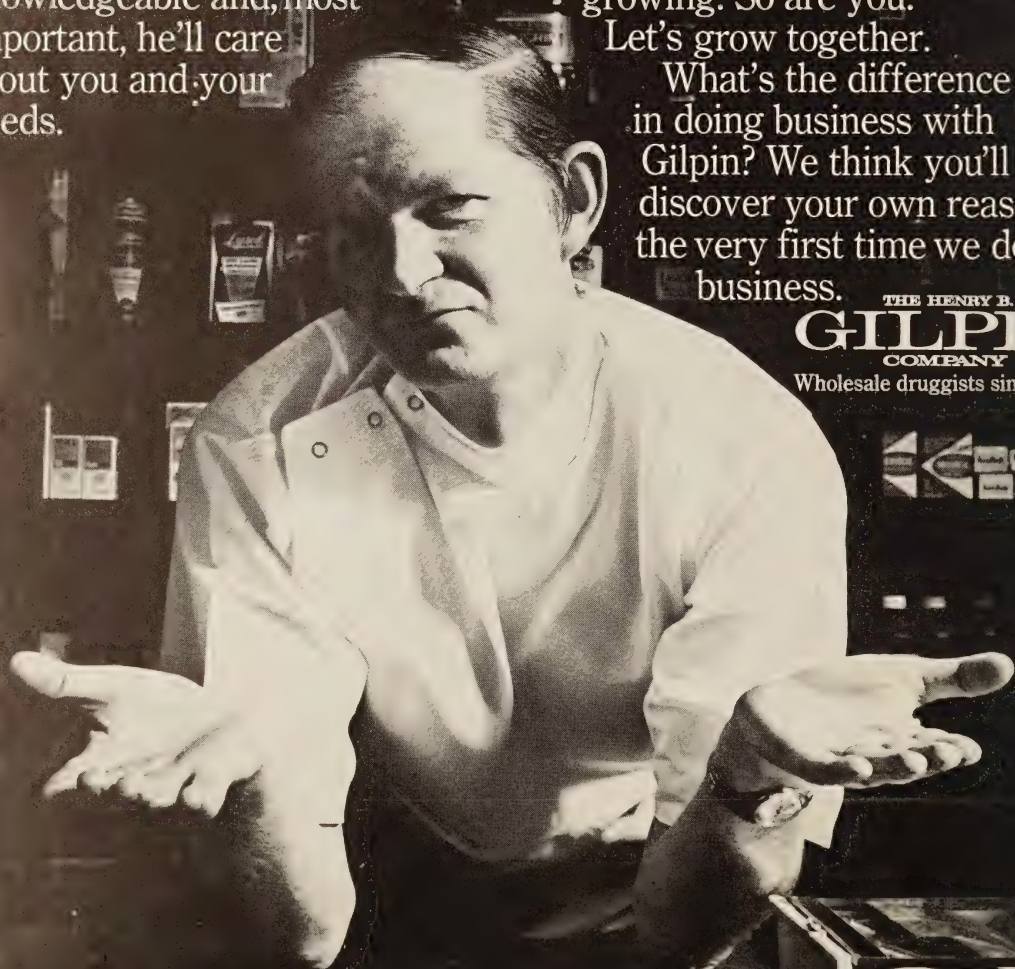
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PUBLIC RELATIONS IMAGERY . . . or HEALTH SERVICE TO THE PUBLIC?

The Maryland Pharmaceutical Association has launched an intensified effort of more effective communication to its various "public"—the general public (patrons/patients) and to specific groups such as allied health professions, consumer groups, legislators, educators and governmental officials. Attention will be given to various decision-makers and molders of opinion.

The emphasis will be on the nature of comprehensive pharmaceutical services and what this means to the public in terms of better health.

Not enough people know what the educational requirements are to become a pharmacist or what the curriculum consists of. Few know that the emphasis in education has changed from the drug product to the patient.

Not enough people know that it is just as important to carefully choose a personal pharmacist as it is to carefully choose a personal lawyer or family physician.

With the potency of today's complex medications, with the concurrent use of several drugs by most patients, with many patients under care by several different medical specialists, only the pharmacist has the expertise and the capability to monitor drug regimens and assure safe, effective, rational therapy.

This is only part of the story of the pharmacist's essential role in health care, in public health and in the community's welfare.

Granted the support of every pharmacist and those in the allied areas serving pharmacy, we will achieve our objective of better information to the public based on pharmacists' health service to the public. Yes, we'll tell facts—not just public relations imagery.

—Nathan I. Gruz

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URGENT!

OSHA Requirements for Employers

The Occupational Safety & Health Act (OSHA) applies to any community pharmacy with one or more employees. Its purpose is to help assure safe and healthful working conditions for every employee by encouraging employers and employees alike to reduce the number of safety and health hazards on the job.

As the employer, you have the responsibility to make your premises free from recognized hazards likely to cause death or serious physical harm. Your employees also are obligated to perform their duties in a safe manner. They should know about the law so they can cooperate. It is really for their benefit.

Federal compliance officers could visit you unannounced some morning to make an inspection. Avoid possible citations and penalties by making an effort to comply with the law now. *Here are a few of the most important things you should be doing:*

1. Put up the OSHA poster in a prominent place for all employees to see.

2. If you had eight or more employees at any one time during 1972, you must complete OSHA form 101 and retain it for five years. You must also maintain Form 100 (a log of individual occupational injuries and illnesses) and prepare Form 102 (a summary of injuries taken from the log). This must be posted at your place of business by February 1 each year for a period of 30 days.

3. Good housekeeping is very much in your favor if the compliance officer calls. Avoid blocking work areas and aisles with cartons of stock or waste materials. Don't leave loose electrical or phone cords where they can cause tripping and falls.

4. Be sure to have a 30-34" high handrail on all stairs with four or more risers.

5. Provide a guard rail 42" high with an intermediate rail for all floor and wall openings from which an employee could fall.

6. Provide adequate fire extinguishers hung in easily accessible locations—five feet high if under 40 lbs. and 3 ½ feet high if over 40 lbs. They should be on a red background. Be sure they're checked and tagged annually.

7. Provide protective equipment to employees using any grinder machines or handling acids, etc.

8. Be sure any air compressor, fan, or other dangerous equipment within 7' of floor or work area has a proper guard to protect the employees.

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MPhA In Action

Board of Trustees Meetings

NATHAN I. GRUZ, *Executive Director*

September 13, 1973

- Received communications from a group advocating use of triplicate prescription form.
- Approved President's report noting extensive publicity in the media regarding surveys of prescription pricing practice in the Baltimore area. The President urged more participation by members, particularly the Board of Trustees, in obtaining new members.
- Approved Treasurer's report.
- The Executive Director reported on major activities which included attendance at meeting of the Maryland State Legislative Council and its committees, the MPhA Peer Review Committee, TAMPA, public relations program through the Community College of Baltimore, meeting with Dr. Rodowskas for an MPhA committee of pharmacists in administrative capacities, BMPA meetings and various third party program matters, particularly in connection with the Medical Care Foundation of Maryland sponsored by the State Medical Society. Mr. Gruz commented on FDA's order placing high potency Vitamins A and D preparations on prescription and on his attendance at the Court of Appeals Hearing of the Board of Pharmacy vs. Sav-A-Lot in which MPhA participated as *amicus curiae*. He pointed out the importance of the Study Commission of Pharmacy established by the AACP on which Past President Morgenroth represents community practice. He emphasized that the work of this Commission may have great effect on the future role of pharmacy in delivery of health care.
- The Executive Director also reported on the MPhA cooperative program with the USP drug product defect reporting program and on activity by COPEs in the third party program area to be reported on at the NARD convention.
- Approved Membership Committee report
- Approved Prescription Insurance Plans Committee report. Announcement was made of the Pharmaceutical Services Foundation appointment of Jerome Mask as Administrative Director. The MPhA list of third party programs in Maryland has been distributed to members. The Chairman commented on the Medicaid program and the use of Average Wholesale Price (AWP) as well as on the 1199 prescription program.
- Heard Peer Review Committee report that various groups and agencies would be advised of the MPhA Peer Review Committee's guidelines and availability.
- Received School of Pharmacy report. The Dean spoke of the excellent esprit de corps of new students and

announced that a fund had been requested for a clinical toxicology center. The Poison Control Center is the sixth largest in the country. Commented on the Commission on Pharmacy of the AACP and that a professional experience program seminar will be held in the near future at College Park. Also reported on inquiry from H. B. Gilpin regarding the Swain Model Pharmacy account which had been settled by MPhA.

- Received Board of Pharmacy report. Mr. Tregoe reported on the forthcoming Tripartite Committee meeting, new reciprocity guidelines being developed for pharmacists who have been out of practice for over five years, on the new regulations on amphetamines and methadone and on problems associated with the dispensing of drugs in the Maryland Penitentiary. He announced his appointment to the Internship Committee of the NABP. The *amicus* brief on the Sav-A-Lot case has been filed by MPhA legal counsel.
- A letter with serious allegations about Division of Drug Control was received with a request for publication. Legal counsel advised that publication was not required.
- Decided not to sponsor a proposed group trip in May because of the trip in February and convention in June.
- Heard Finance Committee report. The Chairman reported that the committee was recommending a \$10.00 increase in dues. Action on recommendations was deferred by the Board.
- Approved Convention Committee report outlining format and plans for the 1974 Convention.
- Authorized Executive Director to appoint MPhA Delegates to the NARD Convention from among qualified members who were in attendance. The Executive Director also reviewed proposed amendments to the NARD Constitution and Bylaws which will be considered at the forthcoming convention in Seattle.

New Members

The following is a list of the new members approved at the Sept. 13, 1973 meeting of the Board of Trustees of the Maryland Pharmaceutical Association:

Philip Chaikin, Baltimore, Rex Pharmacy
Charles E. Leary, Freeland, Ruxton Pharmacy
Charles R. Mund, Student
Frances G. Statter, Baltimore, Revco Pharmacies

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October 4, 1973

- Received report of the Scholarship Committee on the awarding of MPhA scholarship of \$500.00.
- Approved President's report noting progress of convention committee and requesting support of entire board as well as the membership. He expressed satisfaction with the reception that he and Executive Director received at the testimonial dinner for Senator John Bishop of Baltimore County. He urged support of all pharmacists for PHARMPAC (Pharmacists Political Action Committee) which urgently needs funds for its activities. He discussed NARD and Pfizer venereal disease programs. Maryland pharmacists were urged to support the candidacy of the past president Donald O. Fedder for the Board of Trustees of APhA.
- Approved Treasurer's report.
- The Executive Director reported on major activities including Legislative Committee, Tripartite Committee, third-party programs, consumer affairs activities and attendance at the Board of Pharmacy meeting, Regional meeting, BMPA meetings and Senator Bishop testimonial. He discussed the section on "Pharmacists Interests in Nursing Homes" in the report of the Governor's Committee investigating nursing homes and noted that in his testimony to the special State Health Department Committee investigating pharmacy services in nursing homes he recommended that there be a Director of Pharmacy Services for each institution with complete responsibility and establishment of a written procedures manual.
- The Executive Director noted that APhA has received the training contract from HEW to develop educational programs to assist pharmacists in providing pharmaceutical services to nursing homes and related facilities. Samuel Kalman who spoke at the MPhA "Family Planning Workshop" has been appointed director of this program. Dr. George D. Russell, a specialist in adult education, has been appointed Director of Education for APhA.
- The Executive Director commented on the excellent program on "The Pharmacist As A Consultant to Hospitals, Nursing Homes and Extended Care Facilities" presented by the University of Maryland School of Pharmacy. A program on the professional experience program is being presented by the School November 1st and 2nd at College Park under the auspices of the AACP and NABP.
- Approved Membership Committee report.
- Approved the Prescription Insurance Plans Committee report noting that Mr. John Kent, the new Assistant Secretary of Health and Mental Hygiene assigned to Medicaid has agreed to meet with the Pharmacy Subcommittee of the Medical Assistance Advisory Committee about the overall study of pharmaceutical services, drug utilization and expansion of the formulary.
- Approved Convention Committee report outlining the format for the 1974 convention at the Downingtown Inn

with plans for a package at a special rate. The 1974 Convention trip to Israel has 57 already signed up. The possibility of a trip in the Fall of 1974 was discussed.

- Heard the Board of Pharmacy report. A bulletin was sent out regarding regulations on amphetamines, methamphetamines and methadone. The Prince Georges-Montgomery County Pharmaceutical Association has requested the introduction of state legislation to place all exempt narcotics of schedule five on prescription only and the Board of Pharmacy has so noted. There is an attempt within the state to bring all Boards and Commissions together in one department. In the future, the permit to operate a pharmacy will be issued in a format similar to permits for food establishments rather than the special form used in the past by the Board of Pharmacy.
- Approved an increase in dues for pharmacists of \$10.00 for 1974.
- Received Tripartite Committee report. The priorities in which items have been categorized for the coming year are as follows: A—High Priority: 1) Responsibilities of practice such as patient profiles and standards of practice for institutional pharmacy; 2) Standards for assurance of Competency and Continuing Education; 3) Structure of the Board of Pharmacy (residency, additional members, consumer representation); 4) Doctor of Pharmacy program. B—Secondary Priority: 1) State Commission on Practice of Pharmacy; 2) Pharmacy technicians. C—Low Priority: 1) Externship review; 2) Specialty licensure; 3) Third class of drugs.
- Heard Speaker of the House of Delegates report on agenda for October 11 meeting. He stated that the Committee on Bylaws would consist of Henry G. Seidman, Melvin N. Rubin and Edward D. Nussbaum. The report of the Nominating Committee will be acted upon.
- Approved Legislative Committee report noting that the Committee has recommended: a survey of practice of pharmacy in institutions to be conducted by a joint committee of MPhA with MSHP, legislation regarding competency and pharmacy continuing education effective January 1, 1975, amendments to the drug product selection law to be requested through sponsorship by the State Department of Health, amendments to the Board of Pharmacy such as geographical limits and legislation regarding pharmacists' liability in maintenance of drug profiles, third class of drugs. Consideration should be given for establishing an MPhA committee on consumer affairs.

New Members

The following is a list of the new members approved at the October 4, 1973 meeting of the Board of Trustees of the Maryland Pharmaceutical Association:

Dudley A. Demarest, Baltimore, Chief Pharmacist,
North Arundel Hospital
Jackson R. Reed, Hagerstown
Jorja K. Sturek, Cumberland

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Maryland Pharmaceutical Association House of Delegates Meeting

Cross Keys Inn, Baltimore, Md.

October 11, 1973

The meeting was called to order at 10:05 A.M. by Speaker S. Ben Friedman. Secretary Gruz read the roll call.

Edward D. Nussbaum was appointed Parliamentarian. Upon motion by Stanley Yaffe, the minutes of the last House of Delegates session were approved as circulated.

President's report—Anthony G. Padussis: The President's report included the following items: report on APhA Convention in Boston, report on termination of APhA membership in NPIC and formation of COPEs and new associations—Upper Bay and Anne Arundel Pharmaceutical Associations, SAV-A-Lot decision which was still pending; a grant to the North Dakota Pharmaceutical Association for assistance in litigation of pharmacy ownership law before U.S. Supreme Court. Study of pharmaceutical services in nursing homes by joint MPhA-MSHP committee. President Padussis stressed the goal of close relations with MSHP.

A report of the Chairman of the Board of Trustees, Bernard B. Lachman: The Chairman reported on the efforts being made to counteract unfavorable publicity received by the Association as a result of distorted price surveys by consumer groups.

Treasurer's report: The Treasurer noted that a \$10.00 increase in dues would be effective for 1974 for all categories of pharmacist membership.

Executive Director's report: Nathan I. Gruz. Mr. Gruz reported on the Tripartite Committee meetings at which were discussed practical experience requirements, externship, patient profiles, establishing institutional pharmacy practice guidelines as legal regulations, academic changes at the School of Pharmacy (Pharm.D program), ancillary personnel, third class of drugs, continuing education.

Speaker Friedman announced the appointment of a Nominating Committee with Bernard B. Lachman serving as Chairman and including Nathan Schwartz, Dean Wm. J. Kinnard, Stephen Hospodavis and Melvin Sollod. Harry G. Seidman will chair Bylaws Revision Committee with members Melvin N. Rubin and Edward D. Nussbaum.

Legislative Committee report: Paul Freiman: Mr. Freiman reported on the September 25 joint MPhA-MSHP meeting. The Committee will seek legislation for a mandatory continuing education and a Competency Commission will be sought consisting of one Board of

Pharmacy member, one faculty member, three (3) other pharmacists at least one of which will be an institutional pharmacist. The proposed effective date for legislation is January 1, 1975.

The Chairman also reviewed changes being sought to the drug product selection law, to eliminate requirements that pharmacists must contact the physician on each occasion. Legislation will be sought exempting the Peer Review Committee from certain liabilities. The Committee will seek to remove geographic requirements from the Board of Pharmacy and consider the addition of two (2) members to the Board, possibly one a consumer. A third class of drugs is being considered.

Third Party Programs report: Mr. Gruz reported that the matter of Union Local 1199 distributing blank prescription forms to its members will hopefully be resolved. He also pointed out the problem of acquisition cost vs. direct cost.

Prescription Insurance Programs report: Melvin Rubin: The MPhA reference guide on Third Party Plans was mailed out. The Board of Pharmacy has been asked to review the practice by Union 1199 Rx Plan to distribute Rx forms to its members. Mr. Rubin emphasized the need for members to mail in documentation of any problems encountered with Third Party Rx plans. The Committee has addressed itself to Medicaid matters including remuneration, temporary ID cards, manner of payment for unit-dose medication and special form for nursing homes.

Convention Committee report: Paul Freiman: Mr. Freiman announced the Convention would be held from June 23 to June 27, 1974 at the Downingtown Inn in Downingtown, Pennsylvania. Alder Simon reported on the Israel Convention trip of February 18 to 28.

Membership Committee report: Mr. Gruz reported 20 more members as of October 1 compared to the same time last year.

Pharmaceutical Services Foundation: Mr. Gruz noted that Sinai Hospital is the only plan being administered. Jerome Mask has been appointed as part-time administrator.

Peer Review Committee—Irvin Kamenetz reported that Dr. Peter P. Lamy has been asked to serve as Co-Chairman of the MPhA Peer Review Committee. The

Peer Review Guidelines have been approved by the Board of Trustees and next will be presented to the Secretary of Health & Mental Hygiene for consideration. They will then be sent to all third-party programs.

Nominating Committee report: Bernard B. Lachman: the following slate was presented for action by the House of Delegates:

	1973-1974	1974-1975
President Elect	Paul Freiman	Henry G. Seidman Melvin J. Sollod
Vice President	Henry G. Seidman	Irvin Kamenetz Melvin N. Rubin
Treasurer	Morris Lindenbaum	Morris Lindenbaum
Board of Trustees	(to replace R. Snyder)	Guy Dowling Stanley J. Yaffee
	(to replace Melvin Sollod)	S. Ben Friedman Edward Sandel

Moved by James Truitt/Seconded by Paul Freiman and unanimously approved and will be mailed for election by mail ballot. The Speaker and Vice Speaker will be chosen at a later session of the House.

A motion by Paul Freiman that would place MPhA on record as supporting legislation that would bring all Schedule V drugs under prescription was tabled. (Tab-

ling motion by Melvin Rubin/Seconded by Stanley J. Yaffee.)

A resolution introduced by Samuel Morris requesting that the Association endorse publicizing the pharmacist in a more effective manner through a TV dramatic series sponsored by the drug industry was moved for acceptance by Nathan Schwartz/Seconded by James Truitt and passed.

Melvin Rubin announced that the BMPA had a meeting scheduled for November 15 and that the BMPA Installation Banquet would be held on February 3.

The meeting adjourned at 12:15 a.m.

A.Z.O. News

Kappa Chapter of Alpha Zeta Omega Pharmaceutical Fraternity had an Executive Unit meeting on September 17 and a general meeting on September 19 at the Fraternity House. On October 31, the AZO "Center for the Performing Arts" presented a night of fun and surprises featuring the "Watergate Girls" at the Fraternity House. A breakfast meeting was scheduled for November 4 with guest speaker Debbie Roffman on "The Role of the Pharmacist with Respect to Planned Parenthood."

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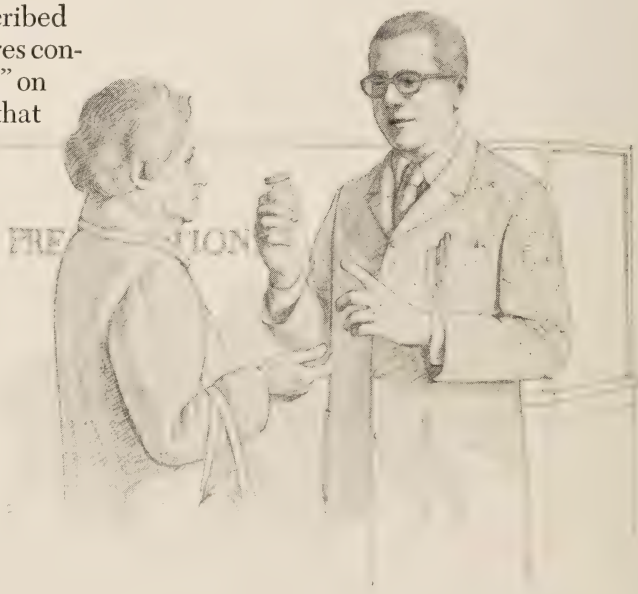
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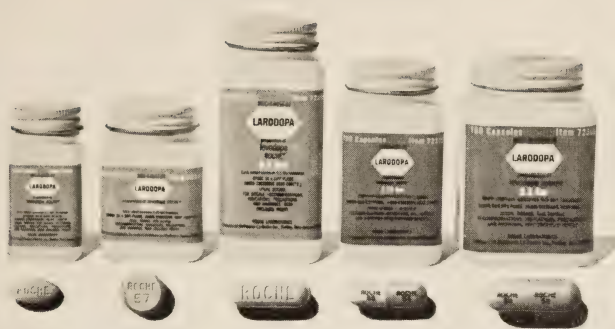
As the most frequently prescribed brand of levodopa, Larodopa assures constant turnover and seldom "expires" on the shelf. Physicians are informed that Roche has the widest pharmacy distribution of all levodopa products and, as leader in the market, has a continuing commitment to levodopa promotion and research.

Larodopa offers consistently high quality—and only Larodopa provides the Roche-patented tablet form of levodopa. The scored, easily divided tablet makes it possible to use a single-strength tablet to vary

the dose as needed. This is both more convenient and less confusing for the patient, as it eliminates the need for multiple prescriptions for capsules of differing strengths.

Consistent with pharmacy-oriented policies, Roche maintains equitable and competitive pricing, assures a liberal "returned goods" credit and does not distribute unsolicited samples of Larodopa (levodopa).





Simplify inventory control by stocking and dispensing

Larodopa[®]
levodopa/Roche[®]

Tablets, conveniently scored for maximum flexibility, 0.1 Gm, 0.25 Gm, 0.5 Gm
Capsules also available, 0.25 Gm, 0.5 Gm

Before prescribing, please consult complete product information, a summary of which follows:

In order to reduce the high incidence of adverse reactions, it is necessary to individualize the therapy and to gradually increase the dosage to the desired therapeutic level.

Indications: For the treatment of idiopathic Parkinson's disease (paralysis agitans), postencephalitic parkinsonism, manganese intoxication, symptomatic parkinsonism due to carbon monoxide intoxication, and parkinsonism in the elderly associated with cerebral arteriosclerosis.

Contraindications: In patients receiving MAO inhibitors (the latter must be discontinued two weeks prior to initiating therapy with Larodopa); in narrow angle glaucoma; and in patients with known hypersensitivity to levodopa.

Warnings: Administer cautiously to patients with severe cardiovascular or pulmonary disease, bronchial asthma, renal, hepatic or endocrine disease. Administer with care and in a facility with a coronary care unit or intensive care unit to patients with myocardial infarction who have residual atrial, nodal or ventricular arrhythmias. Be alert to possibility of upper gastrointestinal hemorrhage in patients with a history of active peptic ulcer disease. Monitor carefully all patients for development of depression with concomitant suicidal tendencies. Treat psychotic patients with caution.

Oral doses of 10 to 25 mg of pyridoxine hydrochloride (vitamin B₆) rapidly reverse the toxic and therapeutic effects of Larodopa (levodopa). Therefore, carefully consider concomitant administration of the two agents. In pregnancy, weigh potential benefits against possible hazards. Do not use in nursing mothers. Safety of Larodopa in children under age 12 not established.

Precautions: Periodic evaluations of hepatic, hematopoietic, cardiovascular and renal function recommended during extended therapy in all patients. Patients with chronic wide angle glaucoma may be treated cautiously provided intraocular pressure is well controlled and monitored carefully during therapy. To patients on an antihypertensive drug, administer carefully, adjusting dosage if necessary. For patients receiving pargyline, see note on MAO inhibitors contraindications.

Adverse Reactions: *Most serious*—occurring most frequently: adventitious movements (e.g., choreiform and/or dystonic); *most serious*—occurring less frequently: cardiac irregularities and/or palpitations, orthostatic hypotensive episodes, brady-

kinetic episodes (the "on-off" phenomena), mental changes including paranoid ideation and psychotic episodes, depression with or without the development of suicidal tendencies, dementia, and urinary retention; *most serious*—occurring rarely: gastrointestinal bleeding, development of duodenal ulcer, hypertension, phlebitis, hemolytic anemia, agranulocytosis, and convulsions. (The causal relationship between convulsions and Larodopa has not been established.)

Less serious—occurring relatively frequently: anorexia, nausea and vomiting with or without abdominal pain and distress, dry mouth, dysphagia, sialorrhea, ataxia, increased hand tremor, headache, dizziness, numbness, weakness and faintness, bruxism, confusion, insomnia, nightmares, hallucinations and delusions, agitation and anxiety, malaise, fatigue and euphoria; *less serious*—occurring less frequently: muscle twitching and blepharospasm (which may be taken as an early sign of over-dosage; consideration of dosage reduction may be made at this time), trismus, burning sensation of the tongue, bitter taste, diarrhea, constipation, flatulence, flushing, skin rash, increased sweating, bizarre breathing patterns, urinary incontinence, diplopia, blurred vision, dilated pupils, hot flashes, weight gain or loss, dark sweat and/or urine; *less serious*—occurring rarely: oculogyric crises, sense of stimulation, hiccups, development of edema, loss of hair, hoarseness, priapism and activation of latent Horner's syndrome.

The following have been noted: elevations of BUN, SGOT, SGPT, LDH, bilirubin, alkaline phosphatase or PBI; occasionally, reductions in WBC, hemoglobin and hematocrit; elevations of uric acid with use of colorimetric method but not with uricase; occasionally, positive Coombs test; leukopenia, requiring at least temporary discontinuance of Larodopa (levodopa).

Dosage and Administration: Because of the necessity for individualizing therapy, the usual optimal therapeutic dosage should not exceed 8 Gm, and should be carefully titrated for each individual patient. The physician should thoroughly familiarize himself with the information in the package insert before instituting therapy.

How Supplied: *Tablets*, pink, scored, containing 0.1 Gm levodopa (imprinted ROCHE 72), bottles of 100; containing 0.25 Gm levodopa (imprinted ROCHE 57) or 0.5 Gm levodopa (imprinted ROCHE 56)—bottles of 100 and 500.

Capsules, containing 0.25 Gm levodopa (pink and beige, imprinted ROCHE 55) or 0.5 Gm levodopa (pink, imprinted ROCHE 54)—bottles of 100 and 500.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

**MPhA-TAMPA-LAMPA Fall Regional Meeting, October 11, 1973,
Cross Keys Inn**



Top Photo—Officers of the Ladies Auxiliary of the Maryland Pharmaceutical Association: Mrs. Richard R. Crane, Communications Secretary; Mrs. S. Ben Friedman, Recording Secretary; Mrs. Anthony G. Padussis, President; Mrs. Harry Schrader, Treasurer; and Mrs. Sol Weiner, Membership Treasurer. Middle Photo: Panel on "OTC Drugs—Is The Pharmacist Needed?": Max N. Richburg, Attorney, Proprietary Association; Donald O. Fedder, President, APHA Academy of General Practice of Pharmacy; Anthony G. Padussis, MPhA President; Paul Freiman, BMPA President and President Elect, MPhA; Dr. Richard D. Penna, Associate Director for Professional Affairs, APHA; Mrs. Thomas Johansson, Junior League of Baltimore; and Dr. Ralph Shangraw, Professor of Pharmacy, University of Maryland School of Pharmacy. Lower Photo: Luncheon Speaker, Dr. William H. Barr, Professor and Chairman, Department of Pharmacy, Medical College of Virginia.

—Photos by Paramount Photo Service

LAMPA News

On Thursday, September 13, 1973, LAMPA went museum hopping in Delaware and Pennsylvania. The bus trip was a sell out. Among those aboard were six pharmacists. Also, two members had their daughters accompany them on the trip, Lee Cooper and daughter Pamela, and Sadie Wagner and daughter Phyllis Wagner Brill. Unusual, handmade dust cloths were given to the daughters, just because we like to encourage mother-daughter attendance at our affairs. While name dropping, we want to mention that Dora Rockman and Sadie Wagner, both former LAMPA officers, were duly recognized for bringing along the most guests. Also, three couples received an "early bird" prize for sending their reservation checks in first. They are: Sam and Marie Jeppi, Harry and Mary Schrader, and Gregory and Marie Leyko.

Coffee and assorted donuts were served while enroute by "uniformed" LAMPA stewardesses. They were Mary Mills, Arlene Padussis, Jo Spigelmire, Dora Rockman and Ann Crane. Their uniforms (colorful handmade aprons) were later given away as bus prizes.

The Harry Francis DuPont Winterthur Museum was our first stop. We separated into small groups and enjoyed a conducted tour of the South Wing. I will not attempt to describe all we saw, but will "capsulate" by saying, "we were glad we came."

The Red Rose Inn, where George Washington is supposed to have dined also was our lunch and rest stop. The quaint, early American decor and the food can both be recommended.

Refreshed and rested, we next visited the Brandywine River Museum which had on special display a joint exhibition with the New Bedford, Massachusetts Whaling Museum, entitled "Whalers, Wharves, and Waterways." Again, I cannot tell all we saw and heard on our conducted tour, except to say we liked what we saw and left more informed and appreciative of Andrew Wyeth and his school of painters.

Since we were in mushroom country, we made the Mushroom Museum our last stop. Here almost everyone purchased some of the "fleshy fungus." On the way home, we conducted an impromptu mushroom recipe exchange. We must have heard how to fix mushrooms in at least 46 different ways. And, as we already know, we have some superb cooks among our members. LAMPA's fourth bus trip had delightful weather, delicious food and as one member summed it up—"It was a great day! When is the next LAMPA trip?"

Fall Regional Meeting

Our Fall Regional Meeting was held at the new Village of Cross Keys Inn in Baltimore on Thursday, October 11, 1973.

To encourage attendance and accommodate the wives of delegates attending the MPhA morning session,

LAMPA planned a visit to the showrooms and plant of the Stieff Silver Company. About 24 members and guests saw how strips and sheets of sterling silver are formed into flatware, how holloware is created and the precise and delicate process of hand engraving and chasing. The group was impressed by the large amount of hand work involved in making the fine silverware we enjoy having and using. Upon completion of the tour, everyone received a "Lucky Coin" as a keepsake. However, Mrs. Albert Ohlendorf was especially lucky, since she won the door prize, a sterling pin tray, purchased from the Stieff Company.

After a bit of browsing and exploring in the new and interesting shops at the Village of Cross Keys, our members enjoyed a gourmet lunch. Dr. William H. Barr of the Medical College of Virginia was the post prandial speaker and spoke on "The Public Interest and the Pharmacist's Role in OTC Drugs."

Our business meeting was conducted by our president, Mrs. Anthony Padussis. All our reports reflected a positive and forward motion for LAMPA. Very favorable comments were expressed about our recent "museum hopping" bus trip. Preliminary plans for the annual convention were also announced.

After the formal meeting adjourned, there was an in-depth discussion regarding possible LAMPA involvement in a drug abuse program, using hand puppets, and addressing itself to the elementary school age group. The proposal is to be studied further at the next Board meeting.

In planning the Fall Regional '73, we tried to fill the day with activity, good fellowship and information—and we think we did.

—Ann Crane
Communications Secretary

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Abrian Bloom (Paramount Photo Service), left, was installed as president of TAMPA for 1973-74 by outgoing president John Matheny (Bay State Associates).

Three Major Barbiturates Transferred To Schedule II

Amobarbital, secobarbital and pentobarbital and their salts alone, in combination with each other, or in combination with other controlled substances were added to Schedule II under the Controlled Substances Act effective December 17, 1973.

As of that date, oral prescription orders for these controlled substances are invalid and prescription orders for them cannot be renewed. On January 1, 1974, an inventory of stocks of these substances must be taken. Schedule II security requirements for storage of these drugs take effect on or before May 13, 1974 with the exception of parenteral forms which are to be stored under refrigeration in compliance with Schedule III regulations. Secobarbital injection is an example of the latter. Each distribution of any of these substances on or after January 1, 1974, must use an official order form.

Eastern Shore Pharmaceutical Society

The Eastern Shore Pharmaceutical Society held its Fall Meeting at the Tidewater Inn in Easton on October 7, 1973. Guest speaker was Congressman Robert Bauman, newly elected representative from Maryland's First District, who spoke on legislation affecting pharmacy and medicine.

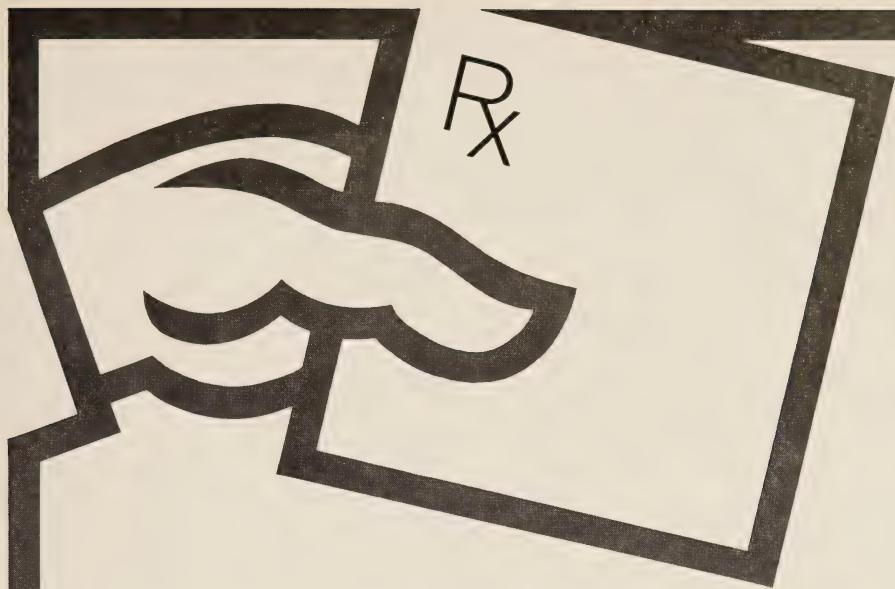
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The Poison Pen

by GARY M. ODERDA, Pharm. D., *Director*
MARY S. FURTH, M.D., M.P.H., *Medical Director*,
Maryland Poison Information Center

How many poisoning calls did you receive last month? Did you feel prepared to answer those calls? Do you know what services the Maryland Poison Information Center offers to you as well as the lay public?

Today's pharmacist, be he hospital or community based has a tremendous professional responsibility to the patients he serves. Part of this responsibility involves protecting the public from toxicity related to the prescription medications he dispenses, and the over the counter products he sells. As a sometimes primary provider of health care, or at least acting as a medical triage person, today's pharmacist must be familiar with and have a working knowledge of common toxicologic problems.

Today's students at the University of Maryland School of Pharmacy receive this training via a didactic toxicology series, case presentations, and rotations through the Maryland Poison Information Center. The Poison Pen is intended to serve as a review for the recent graduate with a toxicology background, and an introduction to toxicology for those pharmacists without this background. The beginning articles of this series will deal with general topics; such as, the use of emetics, dangers in household products, etc. Future articles will also include case reports and discussion of appropriate treatment.

It is appropriate that the introduction to this series also serve as an introduction to the Maryland Poison Information Center. Because of the number of calls this center receives, it is now ranked as the sixth busiest poison center in the United States. Approximately 680 calls per month were answered in 1972 by the Center's staff. The number of calls is increasing steadily. During this July, the Center received over 1200 calls. Approximately 75% of these calls involved ingestions. Included in this group are: drugs, chemicals, foods, household products, plants, snake and insect bites as well as topical and eye exposure. The remaining quarter of our calls are classed as medical inquiries. These calls are from medical personnel as well as the lay public and involve general medical information, identification of foreign drugs, pesticide information, and a little of everything else. As there is no official suicide center, occasional calls are received from suicidal clients and counseling is provided.

The MPIC staff consists of a pharmacist, a pediatrician, a counselor, a research analyst, and five poison control officers. These five officers are especially trained pharmacy and medical students, and they are responsible for manning the Center on weekends, evenings, and nights during the week. The poison control officers have physician backup available while they are on duty.

Referral Procedure:

When notified of an ingestion, pharmacists may call the Center directly or refer the patients to us. Analysis of a poison situation requires a certain amount of informa-

Maryland Board of Pharmacy News

Pharmacy Changes

The following are the pharmacy changes for the month of October:

New Pharmacies

Dart Drug Corporation, Indian Head, Herbert H. Haft, President; 12788 Old Fort Road, Oxon Hill, Maryland 20022.

Rockdale Pharmacy and Medical Equipment, Max B. Meyers, President; 5310 Old Court Road, Randallstown, Maryland 21133.

Giant Pharmacy No. 234, J. B. Danzansky, President; 9200 Baltimore National Pike, Ellicott City, Maryland 21043.

Nichols Salisbury Corporation, I. Rosenbaum, President; Route 13 and Clyde Avenue, Salisbury, Maryland 21801.

Sav-A-Lot Drugs, Willa A. Hillman, President; 1807 Pulaski Highway, Edgewood, Maryland 21040.

No Longer Operating As Pharmacies

Homeland Pharmacy, Joseph W. Loetell, Jr., President; 5306 York Road, Baltimore, Maryland 21212.

Changes of Ownership, Address

Revco Discount Drug Center, D. M. Robinson, President (Change of address); 214-216 West Lexington Street, Baltimore, Maryland 21201.

Pocomoke Pharmacy, Inc., Richard E. Martin, President (Change of address); Route 13 and Linden Avenue, Pocomoke, Maryland 21851.

Thrifty-Wise, Arthur K. Solomon, President (Change of address); 9640 Belair Road, Baltimore, Maryland 21236.

tion as a data base. When calling, please provide all the information listed in Table I that is available to you.

TABLE I

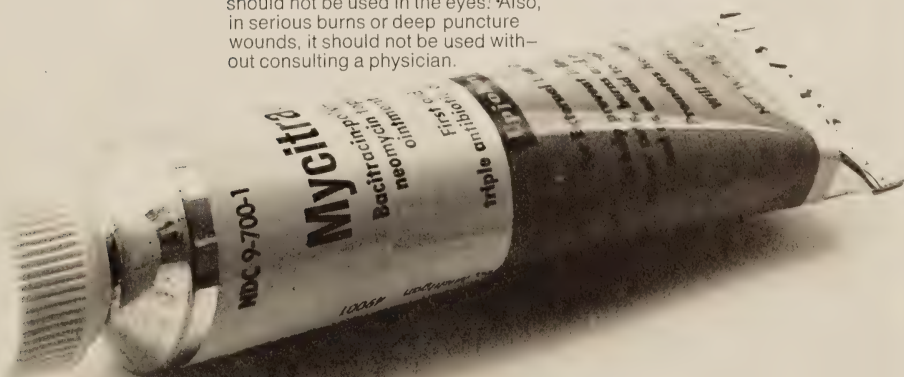
Ingestor's:
Age
Weight
Name
Phone Number
Product's:
Trade Name
Ingredients
Manufacturer and Location
Amount Ingested
Time since ingestion
Symptoms patient is displaying
Previous Treatment (if any)

Please feel free to call the Center when you need help in any of the areas mentioned above. Our phone number is: (301)-1-528-7701

Next month's feature will be a discussion of the use of emetics.

**When
a first aid
ointment
contains
3 antibiotics,
doesn't sting,
is well
tolerated,
helps prevent
infection,
promotes
healing and
gives you an
excellent return
on your money,
it's easy to
recommend.**

Note on the label: Mycitracin should not be used in the eyes. Also, in serious burns or deep puncture wounds, it should not be used without consulting a physician.



Mycitracin®
TRIPLE ANTIBIOTIC OINTMENT

Upjohn

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Slightly Lower Temperatures Have No Effect On Health

Steps taken by national, state and local officials over the last few weeks to meet the energy crisis, may have caused concern by some citizens as to how lowered indoor temperatures might affect their health. To allay any fears, the Bureau of Industrial Hygiene, Baltimore City, reports that there is no evidence that slightly lower temperatures have any adverse effect on a persons health. Usually it is going from overheated indoor temperatures to a cold exterior that can bring on colds.

We are being asked to lower our thermostats during our working hours to between 65 and 68 degrees. While 68 degrees is generally accepted as an ideal temperature for homes and offices, in the past most people raised their thermostats as much as 7 degrees higher. Often this was to offset a lack of proper humidity. It is a fact that adding moisture to the air in winter makes the air feel warmer at lower temperatures. Furnaces without humidifiers should have one installed, but a pan of water on a radiator is a suitable substitute.

For some persons a 68 degree room temperature may be uncomfortable. But the discomfort can be easily offset by wearing more or slightly heavier clothing. It would be wise, for example, to send children to school with a sweater that could be worn or taken off, depending upon how the individual child reacts to lowered classroom temperatures.

It should be emphasized that the lowering of a thermostat by one degree can result in saving 3 to 4 per cent less fuel—a significant daily saving during the present fuel shortage. And it is also important to remember that fuel can be conserved by being certain our heating units are clean and adjusted to make the most efficient use of the fuel we have. The Bureau of Industrial Hygiene is still conducting its free survey of oil burners. Anyone wishing to have his oil furnace tested free may still do so by calling 396-4429.

Robert E. Farber, M.D.
Commissioner of Health

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Thank you for your cooperation.

Nathan I. Gruz, Editor
Maryland Pharmacist
650 West Lombard Street

Rx If you are a pharmacist—
or about to become one—
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- ✓ Recognition and reward for excellence

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a matter of professional interest to the pharmacist
from Merck Sharp & Dohme

there's a great deal being said about hypertension these days... and it's being taken to heart

As a pharmacist, you are well aware that the cardiovascular complications of hypertension can mean early death or crippling disease: congestive heart failure, renal failure, stroke, myocardial infarction.

The prescriptions that you fill for diuretics and other antihypertensive medications are, along with proper diet and weight control, the best preventive measures known against these complications. And the increased number of these prescriptions may have led you to wonder whether the actual incidence of hypertension has risen.

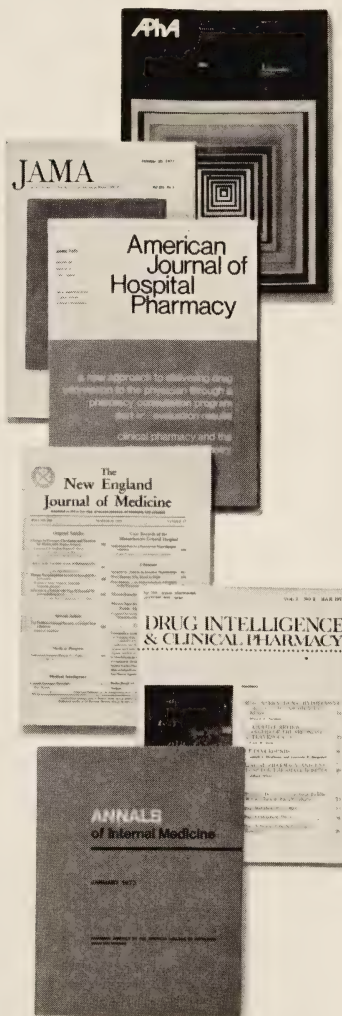
Perhaps it has. But not necessarily. Improved case-finding and physicians' decisions to institute drug treatment at an earlier stage of the disease could also be responsible.

At what reading does hypertension begin?

There are differing views as to where hypertension begins: some physicians say blood pressure readings of 140/90 mm Hg warrant further examination, while others use 160/95 mm Hg as the cutoff. But there is little doubt that a person's risk of developing the complications of hypertension is proportional to his blood pressure level.

Prompt detection and treatment urged

It can be expected that more people will become aware of their hypertension. An estimated 20 million Americans currently suffer from the disease.



A recent report in the *Journal of the American Medical Association* of a study conducted among nearly 23,000 adults employed in the Chicago area revealed that most who had high blood pressure did not know of their condition and that few of those who knew about it were receiving adequate treatment.¹ The editors of the journal urged doctors to "take a more responsible view toward [this] treatable illness."²

A growing body of evidence suggests that prompt detection and treatment substantially lower the risk of serious complications. Toward that end, the creation and funding of a National Hypertension Program were announced in 1972 by former Secretary of Health, Education and Welfare, Elliot L. Richardson.

Vital, growing role of pharmacist

Dr. Theodore Cooper, Director of the National Heart and Lung Institute, which is the focal point for coordinating the activities of this program, views the pharmacist as contributing to its success "both in his capacity as an actual 'health educator' and advisor to the public and in his capacity as a colleague of the prescribing physician."³

1. Schoenberger JA, Stamler J, Shekelle RB, Shekelle S: Current status of hypertension control in an industrial population, *JAMA* 222:559, Oct 30, 1972. 2. Hypertension: A neglected phenomenon, editorial. *JAMA* 222: 579, Oct 30, 1972. 3. Cooper T: The National Hypertension Program, *J Am Pharm Assoc NS13*:135, March 1973.

MSD
MERCK
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&
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MERCK SHARP & DOHME recognizes the vital role played by pharmacists in any therapeutic regimen and is pleased to have brought you this information. We offer our continuing support in keeping you abreast of developments in several medical fields, including the treatment of hypertension.

Letters To The Editor

A physician's valid prescription is filled by a pharmacist in Pharmacy A. The patient decides to have the prescription renewed at Pharmacy B. The pharmacist at Pharmacy B calls the pharmacist at Pharmacy A and is read the patient's prescription by pharmacist A. Pharmacist B is told that the physician indicated refills. The state of Maryland states that pharmacist B cannot fill the prescription unless the physician is called and asked if the prescription which indicates refills is in fact refillable. Now I ask you, what other profession or even licensed craftsman is required to observe such absurdity? What imminent danger exists to the health and welfare of the citizens of Maryland when a pharmacist, licensed to interpret and fill prescriptions, communicates the information of a prescription to another pharmacist via the telephone.

Every day, lay-personnel, employed by physicians, communicate prescription information to licensed pharmacists via the telephone. In many instances these people are not even able to pronounce the names of the medications, yet they are allowed by the state to have a privilege of telephone communication that a university trained and state licensed pharmacist is refused.

Advocates of the present status of "prescription copies" state that *some* pharmacists would not correctly convey to other pharmacists the refill orders of the physician; and thus the patient would be receiving unauthorized refills from theoretically numerous pharmacies. I am waiting for the day when those few pharmacists that are incompetent and dishonest are placed in their proper place, and that is behind the 99.99% of the pharmacists who are honest and conscientious in their practices.

Organized pharmacy must have a thorough review of all the laws regulating the practice of pharmacy. An effort should be made to remove impractical laws or regulations which unjustifiably hinder the professional practice of the pharmacist. Rescinding the "Copy Law" as defined by the state would certainly be a step in that direction.

I would appreciate your comments concerning this subject and all other matters concerning the practice of pharmacy in Maryland.

Mr. Neal Jacobs
Reg. Pharmacist
11809 Randy Lane
Laurel, Md. 20810

RETAIL COST OF ONE UNIT OF HEALTH CARE

	1960	1972
Hospital Charge	\$1.00	\$2.00
Physicians' Fees	1.00	1.45
Dentists' Fees	1.00	1.35
Prescription Charge	1.00	1.02

Source: Cost of Living Index, Bureau of Labor Standards, U. S. Department of Labor.

Maryland Society Of Hospital Pharmacists

The October meeting of the Maryland Society of Hospital Pharmacists was held at the Greater Baltimore Medical Center. Guest speaker was Dr. George Richards, Chief of the Department of Radiation Therapy at Greater Baltimore Medical Center. Dr. Richards discussed drugs used in radiation therapy.

President Thomas Patrick conducted the business session. It was announced that the Joint MPhA-MSHP Legislative Committee had met on September 25. Robert Snyder and Paul Freiman are Co-Chairmen of this committee. Also representing MSHP were Richard Rumrill and Lawrence Hogue. Patrick Birmingham reported on plans of the Partite Committee. Jack Mentzer of the Seminar Committee announced that the 1974 seminar would be held at Williamsburg, Virginia in June.

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In accordance with the provisions of this statute, I hereby request permission to mail the publication named in item 1 at the reduced postage rates presently authorized by 39 U. S. C. 3626. Nathan I. Gruz, Editor

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MARYLAND NEWS COMPANY

Noxell Elects New President



NORBERT A. WITT

GEORGE L. BUNTING, JR.

The Noxell Corporation, in action taken by its Board of Directors, announced two top-level changes in its management. Norbert A. Witt, who has served as President since 1963, has been elected Vice Chairman of the Board, and George L. Bunting, Jr., has been elected President and Chief Executive Officer. Mr. Bunting has served as Executive Vice President of the firm since March 1970 and as a Director since 1968.

Mr. Witt became associated with Noxell Corporation (then Noxzema Chemical Company) in 1955 as Vice President—Sales. In 1960 he was elected Executive Vice President and a member of the Board of Directors. He assumed the position of President in 1963. During his term as President many significant changes have taken place including the change in corporate name from Noxzema Chemical Company to Noxell Corporation; the physical move of the Company to its present site in Cockeysville; the acquisition of Noxzema Chemical Corporation of Canada, Ltd., and the increase in sales from \$28,500,000 in 1963 to over \$83,500,000 in 1972. During this period stockholder equity increased from \$8,500,000 to over \$27,600,000. In his capacity as Vice Chairman, Mr. Witt will maintain an active interest in the affairs of the Company.

George L. Bunting, Jr. is the grandson of Dr. George A. Bunting, founder of the Corporation, and the son of G. Lloyd Bunting, Chairman of the Board. Mr. Bunting joined Noxell in 1966 as a Product Manager. He is a Director of Noxzema Chemical Company of Canada, Ltd., and The Cosmetic, Toiletry & Fragrance Association, Inc. Mr. Bunting serves on the Board of Trustees of the Maryland Institute, Advisory Board of Loyola College, and as an Advisory Director of the Maryland National Bank. A graduate of Loyola High School and Loyola College, he completed his graduate studies at Columbia University Graduate School of Business earning his M.B.A. in Marketing in 1964.

Flu Vaccine Shortage

During the week of October 13th the Maryland Department of Health and Mental Hygiene issued a press release urging members of several vulnerable groups to obtain flu immunization through use of single strain Hong Kong flu vaccine.

Calls from member pharmacists led the Maryland Pharmaceutical Association to determine availability of the vaccine. A survey of local drug suppliers showed that most sources had a very limited or no supply and that in one case a supply existed but was still subject to FDA quarantine prior to release. The survey further revealed that area sources had no firm commitments as to resupply and that existing stocks had been allocated on a priority basis.

"Our problem here is twofold," said MPhA Executive Director Nathan Gruz in a news release published on the situation, "One part of the problem is in the flu itself, which becomes highly resistant to existing vaccines. With this limiting factor national drug producers are reluctant to produce great quantities of a substance which may be obsolete even before the end of one flu season, and so we have a supply problem which is national in scope."

The results of the MPhA survey were widely reported by newspapers, radio and television stations throughout Maryland. WJZ-TV and WMAL radio also interviewed Mr. Gruz at length concerning the situation. MPhA activity brought this vaccine shortage to the attention of many physicians and the FDA's Bureau of Biological Standards.

Prescription Insurance Programs Revisions of Third Party Information

Please note the following changes pertaining to the summary of Third Party Programs information appearing in the September, 1973 issue of *The Maryland Pharmacist*.

1. P. 22 Blue Cross fee—Change from \$1.95 to \$2.10 effective January 1, 1974.
2. P. 24 National Maritime Union (N.M.U.)—Insulin paid at Rx fee. Change phone number to 1-212-757-3627.
3. P. 24 Rx Prescription Plan (1199 Benefit Fund)—Change Birth Control to Yes. Fund allows only 10 day supply on prescriptions except for "chronic conditions" for which 34 days supply is allowed. See drug list in plan booklet for drugs which can be given in 100 dose quantity.
4. P. 26 Prescription Drugs Inc.—Change prescriptions covered under state law to Yes.
5. P. 26 Union Prescription Plan—Add Fund No. 6 to Birth Control coverage.

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Washington Spotlight For Pharmacists

By
APhA Legal Division

Congressional Hearings On Third Party Prescription Programs

The Subcommittee on Environmental Problems Affecting Small Business recently held hearings on pharmacist problems created by third party prepaid prescription programs. Testimony was heard from representatives of the Metropolitan Insurance Company; the Department of Justice, Antitrust Division; and the Federal Trade Commission.

At the outset of the hearings, Representative Hungate (D., MO), Subcommittee Chairman, stated that the idea of General Motors bargaining with independent pharmacies was a disturbing concept. The obvious disparity of bargaining power between independent pharmacies and the insurance companies which administer the prepaid prescription programs was a primary topic as the Congressmen questioned witnesses at the hearings.

Rep. Bergland (D., MN) and Rep. McCollister (R., NB) noted that insurance companies paid pharmacies offering services such as patient medication records, professional consultation, emergency prescription service, and delivery service no more than pharmacies providing none of these services. Therefore, the insurance carrier is, in effect, rewarding the pharmacy which provides the fewest services.

A witness from the Department of Health, Education, and Welfare testified that an inter-agency committee established by the Secretary of Health, Education, and Welfare has been exploring some of the problems created for small business, including independent community pharmacies, by third party prescription programs. A primary concern of the committee is the appropriate delivery of health services, including pharmaceutical services, to the public. The issues considered by the committee include reimbursement policies, administration, and pharmacy services. The final report, due by the end of September, is to discuss alternate approaches intended to minimize the problems and maximize the opportunities for pharmacy participation in the development of third party prescription programs.

Foreign Citizen's Admission To Professional Practice

Most states have required United States citizenship as a prerequisite to practice pharmacy in the state. The following recent decision of the United States Supreme Court regarding the practice of law directly bears on this requirement.

A citizen of the Netherlands came to the United States, married a United States citizen, and became a resident of Connecticut. After graduation from law school, she applied to take the Connecticut bar examination. The

Bar Association found her qualified in all respects except that she was not a citizen of the United States as required by Connecticut law.

The United States Supreme Court has consistently emphasized that classifications based on alienage, like those based on nationality or race, are inherently suspect and subject to close judicial scrutiny. A state which adopts an inherently suspect classification bears a heavy burden of justification. The Supreme Court held that Connecticut did not carry this burden; thus, the Connecticut law was declared unconstitutional.

There is no question that a state does have a constitutionally permissible interest in making a determination of the applicant's character or general fitness requisite for an attorney or other licensed profession. However, in this case, the sole basis for the disqualification is the applicant's status as a resident alien. Thus, a state may properly consider other criteria when examining a person's competence to practice a given profession.

The case of a foreign graduate is, therefore distinguishable from the present case. Here, the foreign citizen graduated from a professional school located in the United States and accredited according to United States Standards. This decision by the United States Supreme Court does not affect the state's right to determine the competence of a foreign graduate making application to practice a licensed profession in the United States.



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PHARMACY CALENDAR

January 17 (Thursday)—Baltimore Metropolitan Pharmaceutical Association meeting, Quality Courts Motel, Beltway & Reisterstown Rd., 8:00 p.m., American Cancer Society Film and speaker John Kent, Assistant Secretary for Medical Care Service, Department of Health and Mental Hygiene.

TAMPA January Meeting, January 24 (Thursday) — Suburban House (Reisterstown Rd. in Pikesville). *Program:* Movie, A Life on The Line Deals with your heart (what to do not to abuse it). How to give first aid to your self or someone near you who suffers a Heart Attack. *Speaker:* Doctor Ali Nayab, Chief of the Cardiac Division, D.C. General Hospital. *Time:* Cocktails Start at 6 p.m. *Dinner:* 7 P.M. Program to follow Dinner. Call Paramount Photo Service for Reservations. 366-1155.

January 27 (Sunday)—Second Annual Alumni Oyster Roast, University of Maryland School of Pharmacy Alumni Association, Overlea Caterers, 6809 Bel Air Rd., 1-6 p.m.

February 3 (Sunday) — Annual Installation Banquet, Baltimore Metropolitan Pharmaceutical Association, Blue Crest North.

February 18-24—Maryland Pharmaceutical Association "Holiday in Israel" with optional extension tours to Rome or Israel.

May 29 (Wednesday)—Graduation Banquet, University of Maryland School of Pharmacy, Eudwood Gardens.

June 23-27—92nd Annual Convention, Maryland Pharmaceutical Association, Downingtown Inn, Downingtown, Pa.

August 3-9—American Pharmaceutical Association Annual Meeting, Chicago.

September 29-October 4—National Association of Retail Druggists Annual Convention, MGM Grand Hotel, Las Vegas.

Obituaries

Morris E. Schucalter

Morris E. Schucalter, 73, 1919 graduate of the University of Maryland, School of Pharmacy, died on October 14. He is the brother of pharmacist Harry Schucalter.

Robert Robinson

Robert Robinson, 70, died in Miami on October 10. He was a 1924 graduate of the University of Maryland, School of Pharmacy.

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NOVEMBER

1973

Volume 49

Number 11

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Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not

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Editorial . . .

LET'S PROMOTE PROFESSIONALISM — NOT PRICE

If one were to survey the public on what factors have to be considered when deciding where to get a prescription dispensed, the majority would answer price as the most important factor. This is because the public tends to think of the pharmacist as a businessman with primarily commercial motivations.

Perhaps we in Pharmacy are to blame for not directing our efforts enough in educating the public about our professional role. The 1972 Dichter report commissioned by the APhA states "The public is unaware of what services the modern community pharmacist performs and, equally important, of the value of these services. Further, today's patient reacts positively to a program of comprehensive pharmaceutical services when he is informed of its features. It should be borne in mind that consumers generally will purchase on other than a price basis—i.e., pay more—if they receive equivalent perceived value or satisfaction in return."

There are many ways in which we can get Pharmacy's message to the public. One of the most effective, direct discourse with the patient, unfortunately seems to be becoming the exception rather than the rule in today's busy pharmacies. Personal attention is very important in establishing a "tie-in" between patient and pharmacist. Even repeating the instructions on the prescription label to the patient can go a long way to show the pharmacist's interest in the patient. Patients return to the same pharmacy when they can identify with that pharmacy. When this identity is established, it is much easier for the patient to understand that the pharmacist is more than a businessman.

Let us not get so involved with the routine operation of our pharmacies that we neglect a very simple, yet effective method of telling our story to the public.

—Normand A. Pelissier

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MPhA Assists In National Diabetes Detection Week Program

The Maryland Pharmaceutical Association and the Baltimore City Health Department joined forces with the Baltimore City Medical Society in the testing for diabetes during National Diabetes Detection Week. Five clinics were held in the Baltimore Metropolitan area. Tests were performed using a reflectance meter, an electronic system that can read chemical blood tests in one and a half minutes, thus providing a quick indication to the person tested whether or not further diabetes testing may be indicated.

It is estimated that there are about 15,000 unknown diabetics in Baltimore City and close to 60,000 in Maryland. Those most likely to have diabetes and be unaware of it are persons over 40, overweight, related to a known diabetic, or women who have given birth to babies weighing more than 9½ pounds.

PHARMACY CALENDAR

February 3 (Sunday)—Annual Installation Banquet, Baltimore Metropolitan Pharmaceutical Association, Blue Crest North.

February 18-24—Maryland Pharmaceutical Association "Holiday in Israel" with optional extension tours to Rome or Israel.

March 17 (Sunday)—Alpha Zeta Omega Pharmaceutical Fraternity Joint Dinner Meeting, Annabel's Hampton Plaza, Towson.

May 29 (Wednesday)—Graduation Banquet, University of Maryland School of Pharmacy, Eudowood Gardens.

June 28-30—Ninth Annual Hospital Pharmacy Seminar, Maryland Society of Hospital Pharmacists, Williamsburg, Virginia.

June 23-27—92nd Annual Convention, Maryland Pharmaceutical Association, Downingtown Inn, Downingtown, Pa.

July 14-18—National Convention, Alpha Zeta Omega Pharmaceutical Fraternity, International Hotel, Freeport, Bahamas.

August 3-9—American Pharmaceutical Association Annual Meeting, Chicago.

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Maryland Pharmaceutical Association

Peer Review Committee

GUIDELINES

Approved by the MPhA Board of Trustees —

June 14, 1973

A. Peer Activity Third Party Prescription Programs

1. Pharmacists judging pharmacists is the most essential component of the Peer Review Committee. The Committee and its Chairman shall be appointed by the President of the Maryland Pharmaceutical Association (MPhA) with the approval of the Board of Trustees of the MPhA and is to be made up of members of various backgrounds; preferably active participants in the third party prescription programs.
2. Term of office of members of the Committee shall be for a period of two years with terms staggered, or at the discretion of the Board of Trustees of the MPhA.
3. All of the proceedings of the Committee must be confidential because of the sensitive nature of the material, and to prevent any unnecessary intrusion into normal and customary patient-provider relations. This, however, does not preclude the providing of required reports to official agencies, regulatory bodies and officials responsible for administering health programs. Final reports shall be made to the MPhA Board of Trustees and where appropriate shall be communicated to the members of the MPhA, the University of Maryland School of Pharmacy, and the general public.
4. Committee members should be scrupulously fair in their deliberations. Where there could exist a personality clash or any hint of self interest, the Committee member must disqualify himself from the proceedings or the Committee may act to disqualify a member.
5. Committee responsibilities in "Drug Utilization Review" objectives are the prescribing and dispensing of the right drug for the right patient, at the right time, in the right amount, and with due consideration of relative costs.
6. Philosophy of the Committee is to achieve its objectives through education and persuasion in obtaining compliance with the accepted standards necessary to provide high quality pharmaceutical services, effective drug utilization practices, and consistent with the level of professional practice within the community.

7. Scope of Peer Review

- a. To protect the patient from any pharmacist who may not adhere to accepted standards of pharmacy practice, the MPhA Code of Ethics, or from the owner of any pharmacy that does not provide those pharmaceutical service benefits required by a particular program.
- b. To protect pharmacists and pharmacies from arbitrary accusations and unreasonable conditions of participation.
- c. To accept documented complaints from all responsible sources involved in the program, including, but not limited to, patients, other health professionals, and program officials.
- d. To review such documented complaints, records and other pertinent information which may be presented to the committee for the purpose of recommending appropriate action.

B. Procedure

When a complaint or matter is brought to the attention of the Committee by the administrators of a program, patients, other pharmacists, or any other individual or agency, the Chairman may:

1. Assign the matter to an individual Committee member for prompt investigation with a report to be made expeditiously to the Committee.
2. Contact provider and request information about the case. Where a provider has been contacted by letter, a reply is expected in writing to the Committee within twenty-one (21) days.
3. The Committee will act on the matter at its next meeting or at a special meeting called by the Chairman, and a statement of disposition of the matter will be furnished in writing, by the staff to the provider and the complainant. Any party to the proceedings may request the opportunity for a personal appearance before the Committee and, upon due notification of the Committee, may be accompanied by legal counsel.
4. Appeal Procedure. Appeals to the decision of the Committee may be taken by any party to the Judicial Board of the MPhA and a request to personally appear before the Board in order to state one's case may be made.
5. In proceedings where physicians are involved, the information may be turned over to the Phy-

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sicians Peer Review Committee or other appropriate body of the Medical and Chirurgical Faculty of Maryland (The State Medical Society). Where other health professionals or health care institutions are involved, the appropriate representative organizations may be advised of the proceedings.

6. The Committee may take one or more of the following actions regarding a pharmacist or pharmacy owner:

- a. Dismiss the complaint or drop the proceedings.
- b. Reprimand (oral or written).
- c. Recommend suspension from a program.
- d. Recommend expulsion from a program.
- e. Recommend partial or full restitution of payments.
- f. Where suspension or revocation of pharmacist's license or of a pharmacy permit may be indicated, appropriate records shall be transmitted to the Maryland Board of Pharmacy.
- g. Other appropriate action.

C. Provider Grievances and Complaints

1. The provider shall initiate action by submitting his grievance or complaint in writing to the appropriate program administrator with a copy to the Peer Review Committee, identifying the claims involved and specifically describing the disputed action or inaction regarding such claims.
2. The program administrator shall be expected to acknowledge the written grievance or complaint within fifteen (15) days of its receipt.
3. The program administrator shall be requested to review merits of the grievance and send a written report of his conclusions and the reason thereof to the provider within thirty (30) days of acknowledgement of receipt of grievance or complaint, with a copy to the Committee.
4. Either party may then refer the grievance or complaint to the Peer Review Committee for adjudication or review.
5. When grievances are brought to the attention of the Committee by the provider, the Committee will proceed as follows:
 - a. Contact the proper administrator of the program concerned and request review, clarification and response to the inquiry and to any Committee comments or recommendations.
 - b. The Committee will act at its next meeting and inform both parties to the dispute of the Committee's decision.

- c. Where there is disagreement with the decision of the program administrator, a meeting of the Committee with the program administrator and provider shall be called.
- d. Following the meeting, if the matter is not solved, the matter shall be referred to the MPhA Board of Trustees for one or more of the following actions:

- (1) Recommendation for a meeting of all providers of a program to decide on a course of further action.
- (2) Where appropriate, bring the facts to the attention of the State Insurance Commissioner.
- (3) Other appropriate action.

D. The Committee, when indicated, may by majority vote recommend revision of these "Guidelines" to the MPhA Board of Trustees.

E. All correspondence concerning the Peer Review Committee should be sent to:

Peer Review Committee
Maryland Pharmaceutical Association
650 West Lombard Street
Baltimore, Maryland 21201

APhA, ASHP Elect New Officers

Robert C. Johnson of California has been elected 1974-1975 President of the American Pharmaceutical Association. President-Elect Johnson received his Bachelor and Master degrees from Wayne State University. He is a past Executive Director of the Michigan Pharmaceutical Association and is Executive Vice President of the California Pharmaceutical Association.

In ASHP balloting, R. Paul Baumgartner, Jr. was elected President-Elect of the American Society of Hospital Pharmacists. Baumgartner is Director of Pharmaceutical Services at the Appalachian Regional Hospitals, South Williamson, Kentucky.

Other APhA officers elected include Joseph E. McSoley of Indianapolis as Vice President and Nick M. Avellone, Angele C. D'Angelo and Donald O. Fedder of Baltimore elected to 1974-1977 terms on the APhA Board of Trustees.

In the ASHP election, Vincent E. Bouchard and David A. Zilz were elected to three-year terms on the Board of Directors.

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Maryland Board of Pharmacy News

Pharmacy Changes

The following are the pharmacy changes for the month of November:

New Pharmacies

The Medicine Shoppe, Marvin L. Oed; 40 Dundalk Avenue, Baltimore, Maryland 21222.

Peoples Service Drug Stores, Inc. No. 280, W. J. Johnson, President; 25 St. Mary's Square Shopping Center, Lexington Park, Maryland 20653.

Revco Discount Drug Center, Sidney Dworkin, President; 9613 Harford Road, Baltimore, Maryland 21234.

Changes of Ownership, Address

Thurmont Pharmacy, Donald and Grace Wenschhof (Change of address—was 12 East Main Street); 15 East Main Street, Thurmont, Maryland 21788.

Preston Pharmacy, Budne C. Reinke, President (Change of ownership); Main Street, Preston, Maryland 21655.

Chandler's Pharmacy, Stephen Needel, President (Change of ownership), 7037 Annapolis Road, Landover Hills, Maryland 20784.

No Longer Operating As Pharmacies

Friedman Drug Company, Inc., N. J. Friedman, President; 701 North Gay Street, Baltimore, Maryland 21202.

Kent Village Pharmacy, Irving Goldberg, President; 7327 Landover Road, Hyattsville, Maryland 20785.

Peninsula Pharmacy, Elizabeth W. Kraus; 400 South Division Street, Salisbury, Maryland 21801.

The following pharmacy was opened in February, 1973: Revco Drug Centers, Sidney Dworkin, President; Tri Town Shopping Center, Westernport, Maryland 21562.

April 16 Deadline For Child-Resistant Packaging

Pharmacists are reminded to order child-resistant packaging supplies now in preparation for the April 16, 1974 legal requirement deadline. The regulation requiring child-resistant packaging for prescription drugs in oral dosage form will go into effect that date, with the only exemption from the order being sublingual dosage forms of nitroglycerin.

Registrations Granted

The Maryland Board of Pharmacy, after canvassing the grades made in the examinations conducted by the Board, has announced that registration will be granted to the following:

Ruth J. Bronder
Donald Brosnahan
Gregory J. Buck
D. W. Campbell
Wayne N. Crowley
Hedy J. Cylus
Robert Jackson, Jr.
Mark C. Jaskulski

Mark R. Miller
Johnny J. Moffett
George E. Meckley
Robert P. Patnode
James E. Ruberg
Rodney D. Rush
James P. Tristani
Samuel C. Simmons

In addition, having previously passed the theoretical examination and by virtue of having passed the practical examination at this time, registration was granted to:

Richard D. Biava
George R. Bolger
David M. Caplan
G. E. Harrington
Carol Ann Hoffman
Martin A. Hoffman
Gary J. Kelley

John A. Kudrick
Joseph L. Marrocco
Kathleen Meckley
Allan L. Schuss
Gary M. Shafer
James M. Spear

The Board also announced that the following persons passed the theoretical examination, but registration is being withheld until they have met the legal requirements for practical pharmacy experience and have passed an examination in practical pharmacy:

Allen N. Chow Douglas K. Ecklund Raymond E. Hollis

Maryland Society of Hospital Pharmacists

The November 8 meeting of the Maryland Society of Hospital Pharmacists was held at the U.S. Public Health Service Hospital in Baltimore. Guest speaker was Dr. Frank Dolle, Associate Professor at the University of Maryland School of Dentistry. Dr. Dolle presented an entertaining and informative talk on "Drugs in Dental Practice." The business session included a discussion on the proposed Doctor of Pharmacy program of the University of Maryland School of Pharmacy.

The Seminar Committee is inviting staff pharmacists to present a paper on their individual developments and procedures at the 1974 annual seminar. Pharmacists wishing to present such a paper should submit a 100 word abstract to the committee. From these abstracts a total of four abstracts will be chosen for possible inclusion in the seminar program. Compensation will be provided to each person selected.



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Annual Report of the Maryland Board of Pharmacy

1972 1973

In compliance with the provisions as set forth in Section 258 of Article 43 of the Annotated Code of Maryland, this report is submitted to the Honorable Marvin Mandel, Governor of Maryland and to the Maryland Pharmaceutical Association. This is the seventy-first report to the Governor of the State and the sixty-first to the Association. The report covers the activities of the Maryland Board of Pharmacy for the fiscal year ending June 30, 1973. This report is also being submitted to the Secretary of Health and Mental Hygiene, the McKeldin Library of the University of Maryland, the Enoch Pratt Free Library, the Department of Legislative Reference, the Hall of Records and the State Library.

Personnel

During the year the Board held fifteen meetings, five of which were held at the School of Pharmacy of the University of Maryland, for the purpose of conducting examinations for registration of pharmacists.

During the 1973 Fiscal Year, Governor Marvin Mandel appointed Mr. Ralph T. Quarles, Sr. as a member of the Board for the remainder of a term of former Secretary F. S. Balassone of five years from May 1, 1969. Governor Marvin Mandel appointed Mr. I. E. Kerpelman as a member of the Board for the remainder of a term of former member, Mr. Howard L. Gordy of five years from May 1, 1973. Governor Marvin Mandel appointed Mr. Charles H. Tregoe as a member of the Board for a term of five years from May 1, 1973, for former member, Mr. Norman J. Levin.

At the meeting of the Board on May 30, 1973, the Board reorganized and elected Mr. Morris R. Yaffe, President, Mr. Charles H. Tregoe, Secretary-Treasurer and Mr. Simon Solomon, Honorary President of the Maryland Board of Pharmacy. The other members of the Board are: Mr. Frank Block, Mr. Ralph T. Quarles and Mr. I. E. Kerpelman.

Examination

The Board conducted two examinations for registration of pharmacists during the fiscal year. They were held at the School of Pharmacy of the University of Maryland on November 13 and 14, 1972 and on June 19, 20 and 21, 1973.

There were sixteen applicants for the full Board in November. Fourteen passed both the theoretical and practical portions of the examination and were subsequently registered. Two failed the examination.

Having previously passed the theoretical portion of the examination, eleven candidates took the practical examination in November. All of these candidates passed and were subsequently registered.

One applicant took only the theoretical portion of the examination which she passed. She will take the practical examination upon completion of her practical experience.

Four applicants took only the practical portion of the examination, as they did not have the required experience for reciprocity. These applicants passed and were subsequently licensed by reciprocity in Maryland.

In June seventy applicants took the full Board examination. Sixty-five passed both the theoretical and practical portions of the examination and were subsequently registered. Five failed this examination.

Having previously passed the theoretical portion of the examination, six applicants took the practical examination. All of these applicants passed this portion of the examination and were subsequently registered.

Twenty-four applicants took only the theoretical portion of the examination as they did not have the required experience to take the full Board. Of these fifteen passed and nine failed this portion of the examination.

Two applicants took only the practical portion of the examination as they did not have the required experience for reciprocity. All of these applicants passed and were subsequently licensed by reciprocity in Maryland.

The Standard Examination of the National Association of Boards of Pharmacy was given, which consisted of the following subjects:

Chemistry
Pharmacy
Mathematics
Pharmacology
Practical Pharmacy

A portion of the theoretical examination was given on Jurisprudence which was compiled by a Board member.

Record of Examinations Held

November 13 and 14, 1972

Applicants	Passed	Withheld	Failed
28	25	1	2

June 19, 20 and 21, 1973

Applicants	Passed	Withheld	Failed
100	71	15	14

Total Number Examined for Registration as Pharmacists

Applicants	Passed	Withheld	Failed
128	96	16	16

The following table shows the number of pharmacists who were registered by examination during the past ten years:

Year	Number of Pharmacists
1963-1964	100
1964-1965	11
1965-1966	64
1966-1967	58
1967-1968	41
1968-1969	60
1969-1970	93
1970-1971	112
1971-1972	133
1972-1973	96

As in the past many pharmacists applied for reciprocal registration in Maryland in order to accept positions with their employers who are opening stores in Maryland.

Those applicants who did not meet our requirements concerning practical experience prior to or after registration were advised that they must take our practical examination in order to verify their qualifications.

In all cases an applicant for reciprocal registration must appear for a personal interview. The entire Board must act on whether or not to grant registration to such applicants, who must sign an agreement to comply with Maryland's laws pertaining to drugs and pharmacy.

The following table shows those granted registration by reciprocity thus far during the 1973 Fiscal Year:

Registered By Reciprocity

Name	Certificate Number	Dated	State
James F. Brown, Jr.	7593	July 10, 1972	Massachusetts
Norman N. Dorosin	7594	July 10, 1972	New York
Gerald W. John	7595	July 10, 1972	Ohio
Richard M. Lemay	7596	July 13, 1972	Connecticut
Douglas B. Kaye	7597	July 17, 1972	Wisconsin
Reatha B. Polk	7598	July 17, 1972	Illinois
Carol E. Stevenson	7599	July 17, 1972	Kansas
Juliana Brown	7600	July 19, 1972	Pennsylvania
Thomas W. Reeder	7601	July 19, 1972	Texas
Thomas S. Sisca	7602	July 19, 1972	Pennsylvania
William H. Ross, III	7651	Aug. 7, 1972	Virginia
John S. Spless	7652	Aug. 7, 1972	New York
Diane Y. Yonekawa	7653	Aug. 7, 1972	Minnesota
Howard K. Galloway	7654	Aug. 21, 1972	Pennsylvania
Gerald H. Polakoff	7655	Aug. 21, 1972	Pennsylvania
Mohammad Aslam	7656	Oct. 10, 1972	Dist. of Columbia
Bernard J. Dunlevy	7657	Oct. 10, 1972	Ohio
Vincent H. Gattione	7658	Oct. 10, 1972	Pennsylvania
Edward W. Grehn	7659	Oct. 10, 1972	Illinois
George W. James	7660	Oct. 10, 1972	Dist. of Columbia
Narendra J. Shah	7661	Oct. 10, 1972	Dist. of Columbia
Marvin E. Silverman	7662	Oct. 10, 1972	Massachusetts
William K. Sutterlin	7663	Oct. 10, 1972	New Jersey
Gary P. Troscial	7664	Oct. 10, 1972	Louisiana
Joseph P. Weaver	7665	Oct. 10, 1972	New Jersey
John R. Cain	7666	Oct. 26, 1972	Georgia
Benjamin L. Barker	7667	Oct. 27, 1972	Iowa
Komala A. Skolnick	7668	Oct. 27, 1972	Dist. of Columbia
Bosco C. Lee	7669	Oct. 30, 1972	Dist. of Columbia
Sankaranarayan Ramakrishnan	7670	Nov. 15, 1972	Dist. of Columbia
John M. Foote, Jr.	7671	Nov. 6, 1972	Texas
Anthony J. Deluca	7691	Nov. 30, 1972	Dist. of Columbia
Dennis R. Day	7692	Dec. 6, 1972	New Jersey
Steven J. Fiorello	7693	Dec. 7, 1972	Connecticut
John P. Kern	7694	Dec. 7, 1972	Ohio
Joan A. Opatken	7695	Dec. 7, 1972	Pennsylvania

Name	Certificate Number	Dated	State
Albert A. Sebok	7696	Dec. 7, 1972	Ohio
Arnold M. Spalter	7697	Dec. 7, 1972	Ohio
George H. Themides	7698	Dec. 7, 1972	Virginia
Stanford M. Werther	7699	Dec. 7, 1972	New Jersey
Phyllis L. Lullinski	7700	Dec. 13, 1972	Illinois
Alphonso Wade, Jr.	7701	Dec. 15, 1972	Ohio
Henry James Mattie	7703	Dec. 23, 1972	Ohio
Harvey H. LeFrock	7705	Jan. 3, 1973	New York
Albert Feldman	7706	Jan. 15, 1973	Dist. of Columbia
Nancy Lee Hoskins	7707	Jan. 8, 1973	Kentucky
Howard J. King	7708	Jan. 8, 1973	Ohio
George Warren Mock	7709	Jan. 8, 1973	Ohio
Annie Laurie St. Paul	7710	Jan. 8, 1973	Louisiana
James Robert Walker	7711	Jan. 8, 1973	Texas
Joel Michael Wolfe	7712	Jan. 8, 1973	Ohio
John Vincent Clark	7714	Jan. 23, 1973	Dist. of Columbia
Robert Frank Davison	7715	Jan. 23, 1973	Pennsylvania
Corbett R. Hyde	7716	Jan. 23, 1973	Virginia
Eugene Jerrell Korn	7717	Jan. 23, 1973	Dist. of Columbia
Bernard Allen Natt	7718	Jan. 23, 1973	New York
Sarah F. Steinhauer	7719	Jan. 23, 1973	Ohio
Irving M. Zieffert	7720	Jan. 23, 1973	Pennsylvania
Jon David Shearer	7727	Jan. 29, 1973	Ohio
Jo Sue Howard	7728	Feb. 5, 1973	Oklahoma
Susan Franzer Salter	7729	Feb. 5, 1973	Kentucky
Henry Roderick Peters	7730	Feb. 20, 1973	Massachusetts
James Edward Trainor	7731	Feb. 20, 1973	New York
Stephen Charles Barnard	7732	Feb. 28, 1973	Virginia
Mescal Arbutus Davis	7733	Feb. 28, 1973	Dist. of Columbia
Ronald Charles Foster	7734	Feb. 28, 1973	Pennsylvania
Paul Eugene Herring	7735	Feb. 28, 1973	Ohio
Gerard Lucien Eugene	7736	Mar. 8, 1973	Louisiana
George Joseph Tabick	7737	Mar. 8, 1973	New York
Arend John Thomas, III	7738	Mar. 8, 1973	Dist. of Columbia
Myron David Winkelman	7739	Mar. 9, 1973	Michigan
Virginia F. Gabriel	7740	April 2, 1973	Dist. of Columbia
Chris Edward Johns	7741	April 2, 1973	Missouri
Evelyn Ching-Fun Ma	7742	April 2, 1973	Dist. of Columbia
Harry Abraham Milman	7743	April 2, 1973	New York
Swetlana Pawlitscheff	7744	April 2, 1973	Texas
Doris Rita Volght	7745	April 2, 1973	New York
Arthur W. Dodds	7746	April 23, 1973	Massachusetts
Linda L. Frankenfeld	7747	April 23, 1973	Iowa
Kenneth W. Richardson	7748	April 23, 1973	Virginia
Lowell P. Fried	7749	April 30, 1973	New York
Harry Sol Kaplan	7750	April 30, 1973	Dist. of Columbia
Allen P. Helchman	7751	April 30, 1973	Massachusetts
Moses A. Bundukamara	7752	May 18, 1973	Iowa
Lee Timothy Grady	7753	May 18, 1973	Illinois
Letha Wallace Lucas	7754	May 18, 1973	Dist. of Columbia
Dorothy C. Stevens	7755	May 18, 1973	Dist. of Columbia
Ingrid R. Baramki	7757	June 12, 1973	West Virginia
Marcus T. Carson	7758	June 12, 1973	Dist. of Columbia
Catherine B. Carter	7759	June 12, 1973	New Mexico
Irwin A. Schaeffer	7760	June 12, 1973	Pennsylvania
Morton Trugman	7761	June 12, 1973	Georgia
Darryl C. Grendahl	7763	June 19, 1973	Minnesota
Philip E. Taylor	7764	June 19, 1973	Oklahoma

The following table shows the number of pharmacists granted registration by reciprocity and the number who were certified to register by reciprocity in other states during the past ten years:

Fiscal Year	Reciprocity	Certified for Registration in Other States
1963-1964	46	23
1964-1965	63	20
1965-1966	44	25
1966-1967	61	27
1967-1968	64	20
1968-1969	84	27
1969-1970	75	40
1970-1971	92	26
1971-1972	67	35
1972-1973	94	57
Total	690	265

The table shows Maryland gained 425 pharmacists by reciprocity during the past ten years.

Pharmacy Permits

Location	1971-1972	1972-1973
Counties:		
Allegany	22	22
Anne Arundel	52	50
Baltimore	143	147
Calvert	2	2
Caroline	3	3
Carroll	14	14
Cecil	7	7
Charles	7	6
Dorchester	4	4
Frederick	14	17
Garrett	3	4
Harford	21	21
Howard	10	11
Kent	3	3
Montgomery	89	92
Prince George's	98	102
Queen Anne's	4	4
Saint Mary's	5	4
Somerset	3	4
Talbot	7	7
Washington	15	17
Wicomico	13	13
Worcester	6	7
County Totals	545	561
Baltimore City	216	200
State-wide Totals	761	761

The above figures include permits issued to hospitals in the counties as follows:

Allegany	2	Howard	1
Anne Arundel	2	Montgomery	4
Baltimore	5	Prince George's	3
Carroll	1	St. Mary's	1
Cecil	1	Talbot	1
Frederick	1	Washington	1
Harford	1	Wicomico	1
		Total	25

In Baltimore City, 17 hospitals received a permit to operate a pharmacy. Thus, a total of 42 hospitals have a licensed pharmacy. Three nursing homes, and one State Penal Institution have received pharmacy permits.

From July 1, 1972 to the present time permits have been issued to 25 new pharmacies. A total of 29 pharmacies have closed and have not, as yet, been re-opened as pharmacies.

The following table shows the number of pharmacies opened, changes in ownership and closed during the year:

	Opened	Changes in Ownership Corporation, and/or Address	Closed
Counties	22	25	14
Baltimore City	3	16	15
Total	25	41	29

The following table shows the number of pharmacies opened, changes in ownership, etc. and closed in the past ten years:

Fiscal Year	Opened	Changes	Closed
1963-1964	20	38	20
1964-1965	22	34	20
1965-1966	27	46	44
1966-1967	41	27	25
1967-1968	24	37	35
1968-1969	34	19	51
1969-1970	20	21	19
1970-1971	24	28	40
1971-1972	27	11	21
1972-1973	25	41	29

Certificate of Registration Renewals

The following shows the renewal periods and the total renewals to date:

Renewal Period	Total Renewals
1961-1962	2,358
1963-1964	2,414
1965-1966	2,651
1967-1968	2,750
1969-1970	2,880
1971-1972	3,043
1973-1974	3,297

Manufacturers' Permits

Permits to manufacture drugs, medicines, toilet articles, dentifrices or cosmetics during 1973 were issued to 39 firms. An applicant applying for a permit for a newly established company is required to appear before the Board and to furnish all information the Board considers pertinent to the conducting of such operation.

Dangerous Drug Distributors' Permits

The Board issued 113 permits to sell, distribute, give or in any way dispose of dangerous drugs during 1973. It is not necessary for a subsidiary or subsidiaries of a company to have a separate permit, as they are covered under the permit held by the parent company.

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Legislation

The following bills were introduced and passed in the 1973 session of the General Assembly and have been signed by Governor Marvin Mandel:

Senate Bill No. 560

AN ACT to repeal and re-enact, with amendments, Section 261 of Article 43 of the Annotated Code of Maryland (1971 Replacement Volume and 1972 Supplement), title "Health," subtitle "Commissioners of Pharmacy," to correct a previous omission relating to the educational qualification for registration as a pharmacist; and modifying the arrangement of this section.

SECTION 1. Be it enacted by the General Assembly of Maryland, That Section 261 of Article 43 of the Annotated Code of Maryland (1971 Replacement Volume "Commissioners of Pharmacy," be and it is hereby repealed and re-enacted, with amendments, to read as follows:

261.

(A) Any person of good moral character, who has had four years' actual experience in a pharmacy where physicians' prescriptions are daily compounded, or has served an internship program regulated by the Board and has attained the age of twenty-one years, who shall present satisfactory evidence to the Maryland Board of Pharmacy that he or she has had at least four years standard high school training or its equivalent, and is a graduate

of a school or college of pharmacy approved by the said Board or accredited by the American Council on Pharmaceutical Education, as published in their official listing and who after examination by the said Board shall be by it deemed competent, shall be registered as a pharmacist and be given a certificate of such registration, provided; however, that not more than three years may be deducted from the four years of actual drugstore experience aforesaid, for the actual time of attendance at a reputable school or college of pharmacy or an internship program to be regulated by said Board be served. Such person shall make application to the secretary of said Board at least ten days before any stated meeting of the Board and shall pay to the said Board a fee of forty dollars.

(B) No applicant for examination before the Board of Pharmacy having the other qualifications herein set forth shall be disapproved because he took his course of studies at a night school or college and nothing in this subtitle shall be held to abridge or abrogate the rights and privileges heretofore conferred by law upon any person now registered as assistant pharmacist in this State.

(C) Any person enrolling as a student of pharmacy in any school or college of pharmacy in this State shall, not later than thirty days after so enrolling, file with the secretary of the Maryland Board of Pharmacy, an application for registration as a student of pharmacy in which said application he shall be required to furnish such information as the Board may deem appropriate, and simul-

taneously with the filing of said application, shall pay to the Board a fee of one dollar; all such students of pharmacy shall, at the beginning of any subsequent school or college year, submit to the said Board a sworn statement of any and all actual drugstore experience acquired during the preceding vacation months or an internship experience acquired during the preceding year as requested by the Board.

SECTION 2. And be it further enacted, That this Act shall take effect July 1, 1973.

Senate Bill No. 564.

AN ACT to add new section 300(g-1) to Article 27 of the Annotated Code of Maryland (1971 Replacement Volume and 1972 Supplement), title "Crimes and Punishments," subtitle "I. Crimes and Punishments," subheading "Health-Controlled Dangerous Substances," to make unlawful the unauthorized manufacture, distribution, and possession with intent to distribute of prescription drugs, certain attempts to obtain prescription drugs, and certain acts and omissions with respect to containers of prescription drugs and labels thereon, and to provide penalties for such acts.

SECTION 1. Be it enacted by the General Assembly of Maryland, That new Section 300(g-1) be and it is hereby added to Article 27 of the Annotated Code of Maryland (1971 Replacement Volume and 1972 Supplement), title "Crimes and Punishments," subtitle "I. Crimes and Punishments," subheading "Health-Controlled Dangerous Substances," to follow immediately after Section 300(g) and to read as follows:

300.

(G-1) Except as authorized by this subheading it is unlawful for any person to:

(1) Manufacture, distribute or possess with intent to distribute a prescription drug.

(2) Obtain or attempt to obtain a prescription drug by (I) fraud, deceit, misrepresentation, or subterfuge, (II) the forgery or alteration of a prescription or a written order, (III) the concealment of any material fact or the use of false name or address, (IV) falsely assuming the title of or representing himself to be a manufacturer, distributor or practitioner, or (V) making or uttering any false or forged prescription or written order.

(3) Affix any false or forged label to a package, container, or other receptacle containing any prescription drug, or to omit, remove, alter, or obliterate any label or symbol on a prescription drug as required by Federal, State or local law.

SECTION 2. And be it further enacted, That this Act shall take effect July 1, 1973.

Senate Bill No. 890

AN ACT to repeal and re-enact, with amendments, Sections 300(a), (d), (e) and (h) of Article 27 of the Annotated Code of Maryland (1971 Replacement Volume and 1972 Supplement), title and subtitle

"Crimes and Punishments," subheading "Health-Controlled Dangerous Substances," to clarify the definition of prescription drugs and to correct the language in these sections referring to prescription drugs.

SECTION 1. Be it enacted by the General Assembly of Maryland, That Sections 300(a), (d), (e) and (h) of Article 27 of the Annotated Code of Maryland (1971 Replacement Volume and 1972 Supplement), title and subtitle "Crimes and Punishments" subheading "Health—Controlled Dangerous Substances," be, and they are hereby, repealed and re-enacted, with amendments, to read as follows:

300.

(a) "Prescription drugs" shall mean and include any drug intended for use by man which, because of its toxicity or other potentiality for harmful affect, or the method of its use, or the collateral measures necessary for its use, bears a cautionary label warning against dispensing without a prescription under Federal law or is designated by the Department as not safe for use except under the supervision of a practitioner licensed by law to administer such drugs. Provided that this term shall not mean any controlled dangerous substance as defined in this subheading.

(d) The provisions of this subheading shall not apply to sales of prescription drugs made to registered practitioners of pharmacy, medicine, dentistry or veterinary medicine, or to sales made by any manufacturer, wholesale druggist, or licensed pharmacist to another manufacturer, wholesale druggist, or licensed pharmacist or to a hospital or institution operating a dispensary in which a practitioner licensed by law to administer prescription drugs is in charge, providing records of such sales are maintained, and available for inspection, showing date of sale, name and address of purchaser, and quantity purchased.

(e) (i) Generally the provisions of this section shall apply to the sale by any manufacturer, wholesale druggist, retail pharmacist, or jobber of prescription drugs, to any person, other than those legally qualified and authorized to purchase and hold same for use or resale, and to any practitioner's assistant who is not legally licensed to administer prescription drugs.

(ii) No person shall be permitted to advertise through any media other than a professional or trade publication any controlled dangerous substance or prescription drug by either its "trade name" or by its generic or formula name.

(h) Any person who violates any of the provisions of this section, or refuses, neglects or fails to comply with the provisions and requirements thereof, or who obtains or possesses a prescription drug in violation of this section, shall be deemed guilty of a misdemeanor and upon conviction thereof shall be fined not more than one thousand dollars (\$1000) and/or imprisoned for not more than two (2) years.

SECTION 2. And be it further enacted, That this Act is hereby declared to be an emergency measure and neces-

I. P. S. F.

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sary for the immediate preservation of the public health and safety and having been passed by a ye and nay vote supported by three-fifths of all the members elected to each of the two Houses of the General Assembly, the same shall take effect from the date of its passage.

Senate Bill No. 1040

AN ACT to add new Section 299 to Article 27 of the Annotated Code of Maryland (1971 Replacement Volume), title "Crimes and Punishments," subtitle "Crimes and Punishments," subheading "Health-Controlled Dangerous Substances," to follow immediately after Section 298 thereof, to provide for payment of funds by the Maryland State Police in connection with purchase of controlled dangerous substances and to provide for reimbursement to appropriations.

SECTION 1. Be it enacted by the General Assembly of Maryland, That new Section 299 be and it is hereby added to Article 27 of the Annotated Code of Maryland (1971 Replacement Volume), title "Crimes and Punishments," subtitle "Crimes and Punishments," subheading, "Health-Controlled Dangerous Substances," to follow immediately after Section 298 thereof, and to read as follows:

299.

(A) The Superintendent of State Police may pay any person, from funds appropriated for the Maryland State Police, Intelligence Division, for information con-

cerning a violation of this subheading a sum or sums of money he deems appropriate, without reference to any monies or rewards to which the person may otherwise be entitled by law.

(B) Moneys expended from appropriations of the Maryland State Police, subsequently recovered shall be reimbursed to the current appropriation for that agency.

(C) The Superintendent of State Police may advance funds in connection with the enforcement of this section.

SECTION 2. And be it further enacted, That this ACT shall take effect July 1, 1973.

House Bill No. 164

AN ACT to repeal and re-enact, with amendments, Sections 266B, 268(a) and 268(c) of Article 43 of the Annotated Code of Maryland (1971 Replacement Volume), title "Health," subtitle "Commissioners of Pharmacy"; to increase the fees paid to the Maryland Board of Pharmacy for permits to operate a pharmacy and renewal thereof and for certificates of renewal of pharmacist licenses; to clarify certain language relating to renewal of permits to operate a pharmacy and late fees; and to correct an obsolete reference.

SECTION 1. Be it enacted by the General Assembly of Maryland, That Sections 266B, 268(a) and 268(c) of Article 43 of the Annotated Code of Maryland (1971 Replacement Volume), title "Health," subtitle "Commis-

sioners of Pharmacy," be and they are hereby repealed and re-enacted, with amendments, to read as follows:

266B.

The Board of Pharmacy shall issue every two years a certificate of renewal, in such form and style as it shall deem proper, to every licensed pharmacist who is entitled thereto and who makes application therefor; these certificates shall be secured every two years on or before the last day of September upon payment of a fee of \$15.00. Any pharmacist who fails for any reason to register or re-register hereunder within the time prescribed shall pay an additional fee of \$2.00 for each renewal period that he shall fail to register or re-register.

268.

(a) It shall be unlawful for any person, copartnership, association or corporation to operate, maintain, open or establish any pharmacy within this State without first having obtained a permit so to do from the Maryland Board of Pharmacy.

The application for such permit shall be made on a form to be prescribed by the said Board of Pharmacy and shall be accompanied by the required fee of forty dollars (\$40.00). For each renewal of a permit, twenty dollars (\$20.00) shall be paid as the fee to the Board of Pharmacy.

If it is desired to operate, maintain, open or establish more than one pharmacy, separate applications shall be made and separate permits issued for each.

(c) Application blanks for renewal permits shall be mailed by the Maryland Board of Pharmacy to each permittee on or before November 1st in each year, and if application for renewal is not made on or before the following 1st day of December, the existing permit shall lapse and become null and void on the date of its expiration, and no new permit will be granted except: (a) upon evidence satisfactory to the said Maryland Board of Pharmacy of good and sufficient grounds for the failure to file the application for renewal within the time prescribed; and (b) upon payment of a late fee of \$5, in addition to the renewal fee.

The said Maryland Board of Pharmacy shall make such rules and regulations, not inconsistent with law, as may be necessary to carry out the purposes and enforce the provisions of this Section, and is hereby authorized, after due notice and opportunity for hearing, to revoke any permit when examination or inspection of the pharmacy shall disclose that such pharmacy is not being conducted according to law or is being so conducted as to endanger the public health or safety.

SECTION 2. And be it further enacted, That this Act shall take effect July 1, 1973.

House Bill No. 1288

AN ACT to repeal and re-enact, with amendments, Section 259 of Article 43 of the Annotated Code of Maryland (1971 Replacement Volume), title "Health," subtitle "Commissioners of Pharmacy," relating generally to the salaries and staff of the members of the Maryland Board of Pharmacy.

SECTION 1. Be it enacted by the General Assembly of Maryland, That Section 259 of Article 43 of the Annotated Code of Maryland (1971 Replacement Volume), title "Health," subtitle "Commissioners of Pharmacy," be and it is hereby repealed and re-enacted, with amendments, to read as follows:

259.

The secretary-treasurer of the said Board and members of the Board shall receive compensation as provided in the budget from time to time and shall be reimbursed for actual expenses. The Board shall have such staff as provided in the budget. All moneys collected under this subtitle shall be paid over to the State Treasurer, and shall become general funds of the State. Such moneys shall thereafter be disbursed by the Comptroller only pursuant to an appropriation made in accordance with ss 32 and 52 of Article 3 of the Constitution or pursuant to the provisions of ss 1 through 15 inclusive, of Article 15A of this Code, title "Budget and Procurement," as amended from time to time.

SECTION 2. And be it further enacted, That this Act shall take effect July 1, 1973.

House Bill No. 1309—In part

AN ACT to repeal and re-enact, with amendments, Section 279(b) and (c) of Article 27 of the Annotated Code of Maryland (1972 Supplement), title "Crimes and Punishments," subtitle "I Crimes and Punishments," subheading "Health-Controlled Dangerous Substances," to reschedule certain controlled dangerous substances, relettering and adding new substances to the schedules.

279.

C. Any material, compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs, or any salts thereof:

D. Talwin

E. Methaqualone

SECTION 2. And be it further enacted, That this Act shall take effect July 1, 1973.

Cooperative Activities

The Board maintained membership in the National Association of Boards of Pharmacy. The annual meeting of the Association was held in Scottsdale, Arizona, April 25 - May 2, 1973. The Board was represented by Secretary Frank Block.

The Board also maintained membership in the Conference of Boards and Colleges of Pharmacy of the National Association of Boards of Pharmacy, District Number Two, comprising the states of New York, New Jersey, Pennsylvania, Delaware, Maryland, the District of Columbia, Virginia and West Virginia. The annual meeting was held in White Sulphur Springs, West Virginia on October 19 - 21, 1972. The Board was represented by Mr. Frank Block and Mr. Morris R. Yaffe.

The Board maintained cooperative activities with the State Department of Health and Mental Hygiene, the

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School of Pharmacy—University of Maryland, the Maryland Pharmaceutical Association, the Baltimore Metropolitan Pharmaceutical Association, Federal Bureau of Narcotics and Dangerous Drugs, Food and Drug Administration, City, County and State Police.

Prescription Survey

The following table shows a survey of prescriptions filled in 1972:

PRESCRIPTION SURVEY 1972

Baltimore City

Average Number New Prescriptions Filled in 80 out of 187 Pharmacies	15,163	
Average Number Prescriptions Refilled in 80 out of 187 Pharmacies	6,752	21,915

Average Price of Prescriptions in 80 out of 187 Pharmacies	\$4.01	
Estimated New Prescriptions Filled in 187 Pharmacies	2,835,481	
Estimated Prescriptions Refilled in 187 Pharmacies	1,172,624	4,008,105

Counties

Average Number New Prescriptions Filled in 223 out of 535 Pharmacies	17,309	
Average Number Prescriptions Refilled in 223 out of 535 Pharmacies	12,526	29,835

Average Price of Prescriptions in 223 out of 535 Pharmacies	\$4.01	
Estimated New Prescriptions Filled in 535 Pharmacies	9,260,315	
Estimated Prescriptions Refilled in 535 Pharmacies	7,701,410	16,961,725

State

Estimated New Prescriptions Filled in 722 Pharmacies	12,095,796	
Estimated Prescriptions Refilled in 722 Pharmacies	8,874,034	20,969,830

Finances

All funds of the Board of Pharmacy are deposited to the credit of the Treasurer of the State of Maryland, and disbursements covering the expenses of the Board are paid by voucher by the State Comptroller.

FINANCIAL STATEMENT — MARYLAND BOARD OF PHARMACY

1973 Fiscal Year

Budgeted	\$10,761.00
Budget Credits	147.52
Total Available	10,908.52
Expenditures	10,904.33
Unexpended Balance	4.19
Unliquidated Encumbrances	.00
Unencumbered Balance	\$ 4.19

Respectfully submitted,

C. Tregoe
Secretary-Treasurer
Maryland Board of Pharmacy



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Continuing Education For Pharmacists —

University of Maryland School of Pharmacy

NON-PRESCRIPTION (O.T.C.) DRUGS AND SELF MEDICATION

February 5 - May 10, 1974

Combination: 8 Tuesday evening lectures and independent study

A major responsibility of the pharmacist lies in the area of non-prescription drugs. The pharmacist is often asked for recommendations on the proper selection of these preparations and the responsibility not only for the choice but the dissemination of information regarding use and precautions must properly reside with him.

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The course will focus on all aspects of self medication with emphasis on those drugs which are available to the public without prescription. Topics include philosophy, traditions of self medication, efficacy, toxicology, labeling, consumer interests and pharmacists obligations.

Included in the course will be a review of O.T.C. drug products in the more important therapeutic categories including pharmacology, physiologic states, composition of products available and specificity of action, interactions, side effects, warnings and cautions, and labeling.

The course will be held at the Allied Health Professions Building School of Pharmacy (Room 210) on Tuesday evenings from 7:30 to 9:30 P.M. for 8 weeks beginning February 5, 1974. Following the eight weeks of lectures the course will continue by means of cassette tapes for independent study. Both fifth year students and practitioners will join in this course.

Cassette tapes and study materials will be available for individual or group use.

Course Fee: \$35.00 plus text and materials

Text: Current issue of "The Handbook of Non-Prescription Drugs," American Pharmaceutical Association

Cassette Course, 8 Lectures, 16 hours (includes study material): \$35.00. Study material only, \$12.50. Must be used with another registrant who has tapes.

Course Director: Benjamin Hodes, Ph.D.

Assistant Professor, Department of Pharmacy
University of Maryland School of Pharmacy

ANTIBIOTICS IN PHARMACY PRACTICE will be presented

February 13, 1974

Holiday Inn, Laurel, Maryland
Route 198, West of Baltimore-Washington Pkwy.

April 24, 1974

Holiday Inn, Easton, Maryland
on Route 50 one mile south of Easton

A discussion of the production, chemistry, mechanism of action, spectrum, use, side effects and incompatibilities of the major classes of antibiotic substances. There will be a short discussion on the history of production of antibiotics followed by topics concerned with the choice of antibiotics, and relevant material on mechanism of action and affect on bacterial resistance, and the effects of chemical changes on bioavailability, spectrum and resistance. The major portion of the course will be devoted to clinical and pharmaceutical aspects of the major groups of antibiotics and discussions of the more important compounds within each class.

Course Director: Ralph N. Blomster, Ph.D.

Professor and Chairman
Department of Pharmacognosy
University of Maryland School of Pharmacy

REGISTRATION INFORMATION

Registration from 9:00 to 9:30 a.m.

Cost for the entire day is \$20.00, including full course lunch and coffee breaks.

Other allied health professionals are invited to attend this course.

MAIL TO: UNIVERSITY OF MARYLAND SCHOOL OF PHARMACY 636 W. LOMBARD ST., BALTIMORE, MD. 21201

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TAMPA News

The Travelers' Auxiliary of the Maryland Pharmaceutical Association celebrated Ladies Night at the Oregon Ridge Dinner Theatre on November 8, 1973. Dinner was served buffet style followed by the play "Catch Me If You Can." The combined comedy and mystery was given by a lively and entertaining cast. Guests included Nathan I. Gruz, Executive Director of MPhA and BMPA and Anthony G. Padussis, President of MPhA.

A. Z. O. News

David Roffman of the University of Maryland School of Pharmacy was scheduled to speak on "Current Trends In Clinical Pharmacy" at the December 19 meeting of Alpha Zeta Omega Pharmaceutical Fraternity. The list

of activities scheduled for the new year begins with a dinner show at Bolton Hill Dinner Theatre on January 20 featuring the show "Pajama Tops."

The A.Z.O. Joint Dinner Meeting is being held this year at Annabel's, Towson, on March 17. The national convention is slated for July 14-18 in Freeport, Bahamas.

Obituaries

George B. Dawson

George B. Dawson, 73, 1921 graduate of the Milton University School of Pharmacy, died on November 5.

Louis L. Meyers

Lewis L. Meyers, 69, died on November 20. He was a 1927 graduate of the University of Maryland School of Pharmacy.

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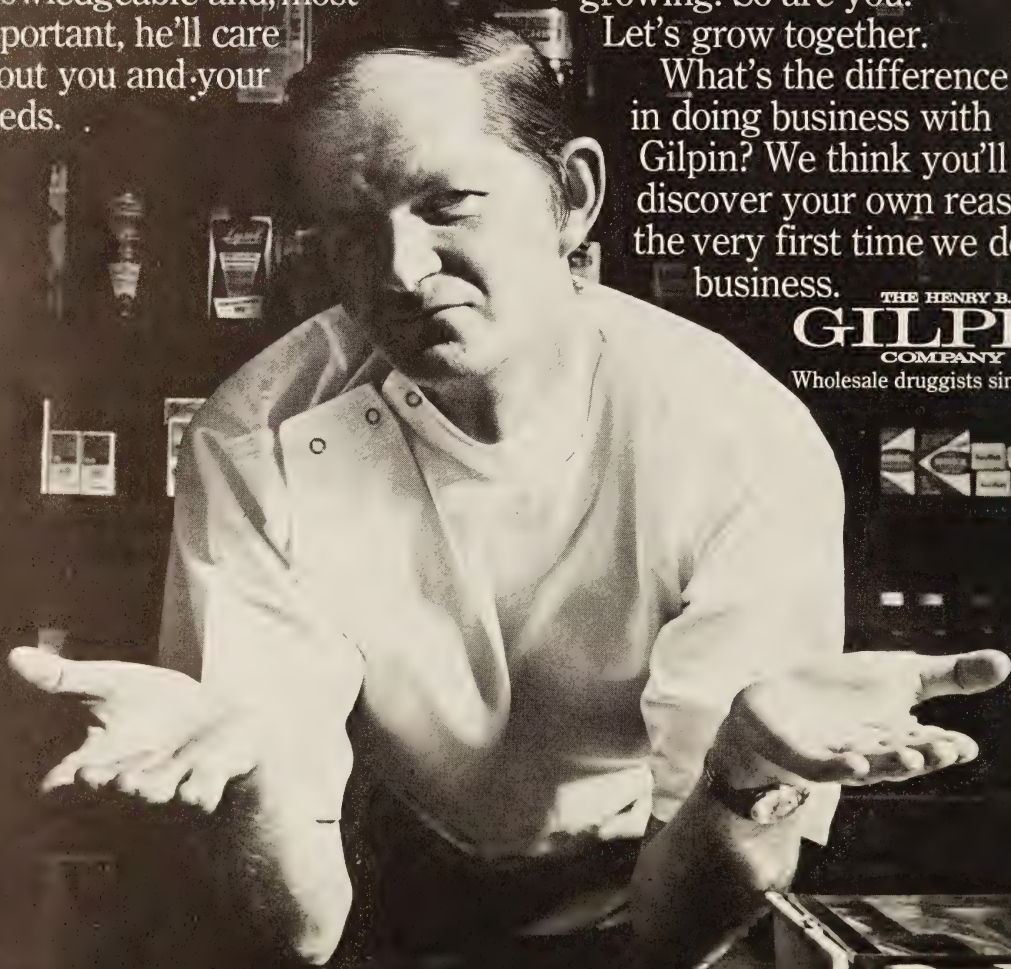
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the maryland pharmacist

DECEMBER
1973
Volume 49
Number 12

The Poison Pen – *Emetics*

by Gary M. Oderda, Pharm. D. and
Mary S. Furth, M.D., M.P.H.

U.S.P. Drug Defect Reporting Program

Some Principles For The Use Of Drugs

by J. Tyrone Gibson, Ph.D.

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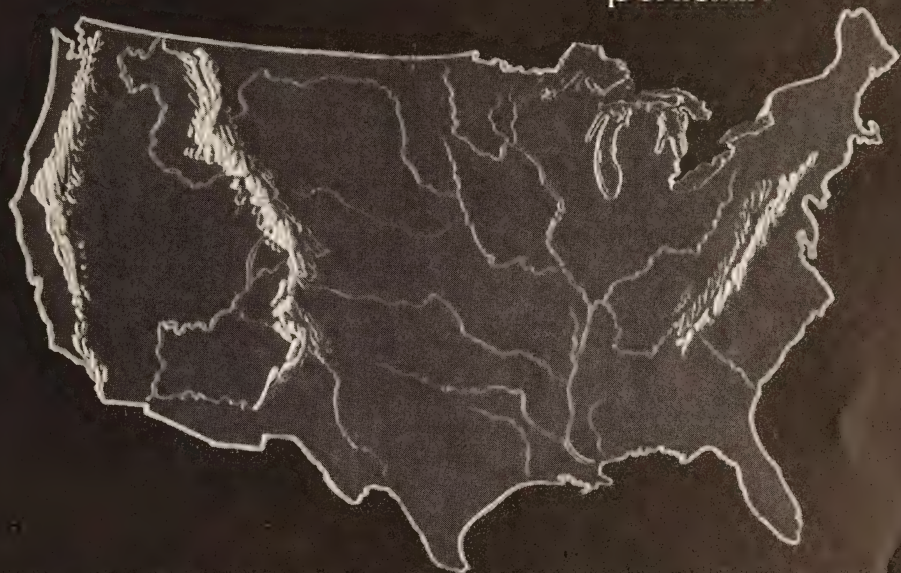
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Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not

rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin.

*equivalent to phenoxymethyl penicillin

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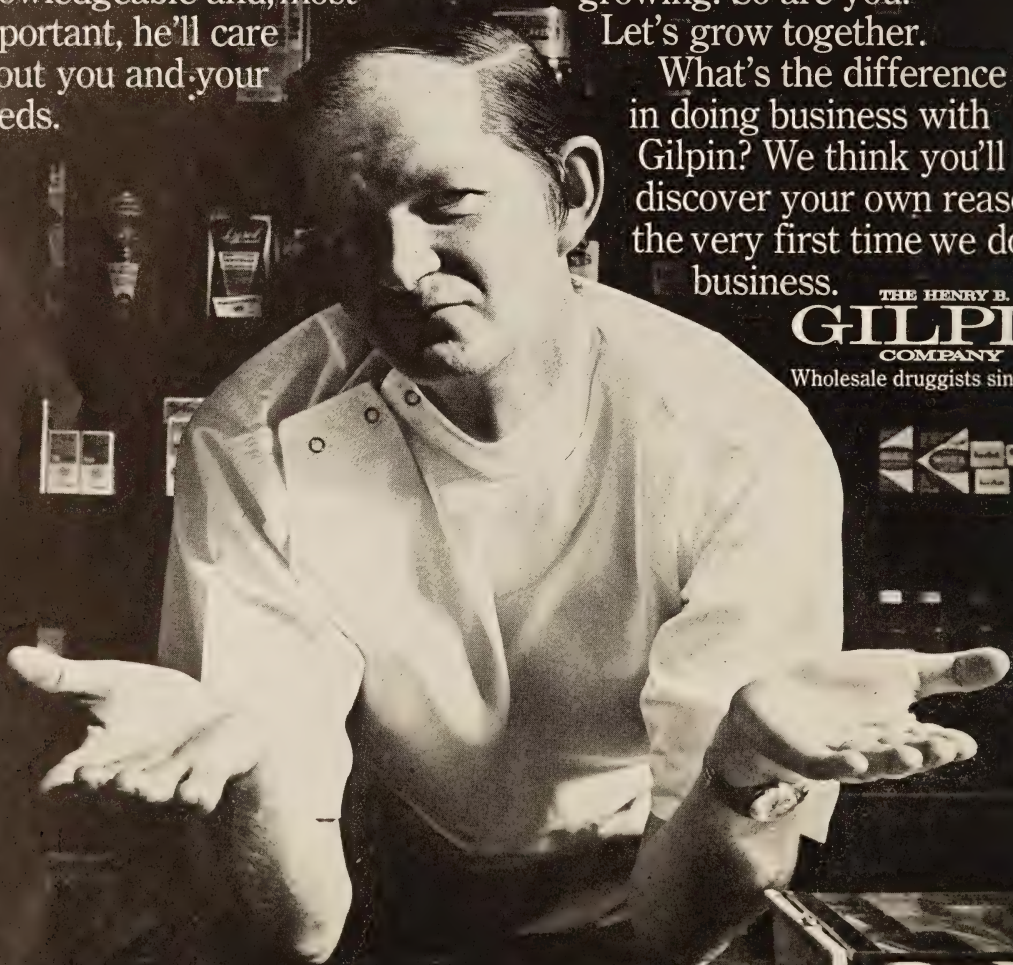
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PARTICIPATION MUST PARALLEL EXPANSION OF ROLE

The increase in public pressure in the form of proposed legislation by numerous capitol hill legislators and consumer groups is ample evidence that improvements to our health care system are necessary. Some of these changes being sought are in the area of drug prescribing and dispensing and thus will directly affect the practice of Pharmacy.

Recent proposed legislation by Senator Edward M. Kennedy is aimed at decreasing the vast toll of injuries and deaths resulting from adverse drug reactions. One proposed method of accomplishing this is the elimination of trade names as a means of providing doctors with more authoritative prescribing information with minimum of confusion. Senator Kennedy points to government data showing that adverse drug reactions account annually for 30,000 deaths; for about 1.5 million hospital admissions, or up to 4 to 7 per cent of the total, and for costs of about \$2.25 billion. About \$1.2 billion could be saved by a "comprehensive system of prevention," according to Senator Kennedy.

The Department of Health, Education and Welfare recently announced that it is planning a new policy under which it will pay for drugs covered by Medicare and Medicaid only at the lowest price for which the drugs are generally available.

Consumer advocate Ralph Nader, in recent testimony before a Senate health subcommittee, stated that substitution for generic drugs for brand-name drugs would save consumers hundreds of millions of dollars annually.

Whether it can be proven that these ideas are sound or not, some sort of reform seems inevitable. The question which arises is will the pharmacist be able to assume the responsibility of greater decision making which will fall upon him? We think the answer is yes providing the individual practitioner maintains his interest in the profession by active participation in his association, by keeping his information current through participation in continuing education programs and by strengthening his professional standing in the eyes of the public.

—Normand A. Pelissier

Active vs. Passive Membership

The December, 1973 issue of *The White Sheet* carried the following two paragraphs which first appeared in *Nation's Business*, July, 1973. The words businessman and business have been replaced with the words pharmacist and pharmacy.

"Mr. Pharmacist: You can't lose weight or tone your muscles by carrying a health club membership card in your pocket. You must get in there and do the knee bends, and ride the bicycles, and run the track . . . and pretty soon, you're robust, healthy and trim. But you've got to keep participating to keep that way!

"Similarly, your pharmacy won't get robust, healthy and trim if you only carry your association membership card around in your pocket. You must participate. You must serve on committees, attend meetings, write your Congressman, and do all the other things that active members are expected to do. And you must keep doing it to keep your pharmacy healthy! So, flex your pharmacy muscle . . . get involved in your professional association."

PHARMACY CALENDAR

March 17 (Sunday)—Alpha Zeta Omega Pharmaceutical Fraternity Joint Dinner Meeting, Annabel's Hampton Plaza, Towson.

March 28 (Thursday)—University of Maryland School of Pharmacy Alumni Association Dinner, Mercantile Club.

May 29 (Wednesday)—Graduation Banquet, University of Maryland School of Pharmacy, Eudowood Gardens.

June 28-30—Ninth Annual Hospital Pharmacy Seminar, Maryland Society of Hospital Pharmacists, Williamsburg, Virginia.

June 23-27—92nd Annual Convention, Maryland Pharmaceutical Association, Downingtown Inn, Downingtown, Pa.

July 14-18—National Convention, Alpha Zeta Omega Pharmaceutical Fraternity, International Hotel, Freeport, Bahamas.

August 3-9—American Pharmaceutical Association Annual Meeting, Chicago.

September 29-October 4—National Association of Retail Druggists Annual Convention, MGM Grand Hotel, Las Vegas.

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Leahmer M. Kantner



Leahmer M. Kantner, former Chief of the Division of Drug Control in the State Department of Health and Mental Hygiene, died on November 3 at 86 years old. He was Chief of the Division of Drug Control from 1940 to 1955 and also served as Secretary of the State Board of Pharmacy being appointed in 1934 and reappointed by three governors. Mr. Kantner received his pharmacy degree from the University of Maryland in 1909. He was a member of the Legislative Committee of the American Pharmaceutical Association and President of the Baltimore branch of the APhA. In 1953, he was named Honorary President of the Maryland Pharmaceutical Association, which he had headed 21 years before.

A former Vice President of District 2 of the Boards and Colleges of Pharmacy, he was a member of the American Foundation for Pharmaceutical Education, the National Association of Retail Druggists, the Central Atlantic States Food and Drug Officials and the Baltimore Veteran Druggists Association.

Scarcities And Inflation May Increase Theft Of Company Property

As the nation's shortages increase, so does the risk from internal theft faced by many companies. Pharmacy proprietors should take a fresh look at the situation now. A quick glance through the following checklist may suggest needed steps:

- 1—Limit the areas of opportunity for thieves to carry items off the premises or give them to outsiders. This is done by permanently closing off unnecessary doors and windows, barring windows, and providing general security for the entire property. If necessary add fences and lighting.
- 2—Request identification from strangers who are carrying packages or making pickups. Make surprise checks to insure that nothing—boxes, packages, equipment, etc.—is going out of the pharmacy without authorized approval.
- 3—Change locks and keys from time to time. Keep duplicates in a safe, not hanging on an accessible hook.
- 4—Take a physical count of supplies and critical inventory items at random times. Pay special attention to scarce, high-value items.
- 5—Keep records on scrap, seconds, and returns of high-value materials and have waste and damaged goods examined periodically to verify that the records are correct. Dishonest employees may "create" scrap in order to take it themselves.
- 6—Tighten employee selection procedures so you don't hire thieves. Make sure that sufficient background data are collected during interviews and that references are thoroughly checked.
- 7—Bond your key employees. Not only will the carrier screen employees but it will provide you with advice about how to handle problems relating to internal crimes.

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Nathan I. Gruz, Editor
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The Poison Pen

Emetics

by G. M. ODERDA, Pharm. D.
and M. S. FURTH, M.D., M.P.H.

Maryland Poison Information Center
University of Maryland School of Pharmacy

Since ingestions occur via the oral route, an important procedure in acute poisoning is to empty the stomach. The trend in management has favored emptying the stomach by emesis with syrup of ipecac or apomorphine over gastric lavage.¹ Recent studies have shown a more efficient removal from the stomach through the induction of emesis.^{2,3,4} This greater efficacy is attributable in part to some emptying of the upper small intestine (duodenum) as well as the stomach. Emesis, which is more convenient, can also recover materials too large to pass through the lavage tube.

Vomiting can only be produced if the brain's medullary centers are still responsive. If the patient is unconscious, emetics may be ineffective as well as dangerous. If the unconscious patient does vomit, the possibility exists that some of the vomitus may enter the trachea and thus the lungs (aspiration) and cause severe respiratory problems. Emetics may precipitate convulsions in a susceptible individual. These agents should not be used in an individual who is convulsing or has ingested a known convulsant (camphor, for example). Strong acids and bases may cause severe esophageal burns, if swallowed. If vomiting were induced, the esophagus would be further traumatized by additional exposure to these agents. Esophageal perforation is also possible. Vomiting should not then be induced after ingestion of a caustic. Petroleum distillates, gasoline for example, pose a significant aspiration risk if vomiting occurs. Some toxicologists feel that vomiting induced with apomorphine or ipecac is forceful enough that aspiration is not a hazard.⁵ At this time, however, it is the feeling of the Maryland Poison Information Center (MPIC) that emesis should not be induced in an individual who has swallowed a petroleum distillate. Ingestion of an antiemetic agent, phenothiazines for example, are a relative contraindication to the use of emetics. Current recommendations indicate that emetics may be successfully used within one hour of ingestion of an antiemetic.^{6,7} The table below summarizes the contraindications for the use of emetics:

Contraindications of Emetics Use

1. Unconscious Patient.
2. Convulsing Patient or Ingestion of a Convulsant.
3. Ingestion of a Petroleum Distillate.
4. Ingestion of a Caustic.
5. Ingestion of an Antiemetic.

Ipecac:

Syrup of ipecac is an emetic preparation whose botanical origin is the *Ipecacuanha* Root. Ipecac produces

vomiting by both a central and local effect. Locally, the ipecac causes a direct irritation of the gastric mucosa. Absorbed ipecac also produces vomiting through a central effect in the brain's vomiting center. For most uses, ipecac must be considered the emetic of first choice. The FDA approves the over-the-counter sale of appropriately labeled one ounce containers of ipecac syrup. Fluid extract of ipecac (14 times stronger than the syrup) should NEVER be used. Deaths have been reported in situations where fluid extract was mistakenly dispensed for syrup of ipecac.⁸ Syrup of ipecac is highly efficient, when administered properly, and can be expected to produce vomiting in 15 to 20 minutes. Although ipecac can produce toxicity itself, the entire one ounce container can be ingested by a child over one year of age without danger. Although syrup of ipecac may be administered to children under one year of age, it is not recommended that this be done without medical supervision. All individuals over one year of age should be given the same dose: one tablespoonful (one half of the one ounce container). Emetics do not work if the stomach is nearly empty. For this reason, 8 ounces of a clear liquid should be given immediately after the ipecac. Water, fruit juice, or kool-aid are all appropriate. Milk should not be given as it interferes with ipecac's action. If vomiting is not successful in 20 minutes, another tablespoonful of ipecac and 8 ounces of fluid should be given. If still unsuccessful, lying the child down or gagging him may help. If the child is transported by automobile, a person to take care of the child in addition to the driver must be included. It is also important to bring along a container to catch the vomitus. After vomiting successfully, the individual should not eat or drink anything for at least one and one half (1½) hours. Doing so before this time may lead to more vomiting. This is a deterrent when one wants to use activated charcoal. Trauma from vomiting as well as the effect of the ipecac tend to make children tired. If one is fairly certain it is this that is causing drowsiness and not the ingested agent, it is acceptable to allow the child to go to sleep. It is important, however, that the child be checked periodically by the parent.

Apomorphine:

Apomorphine is a morphine derivative that produces emesis through a central action. It acts very quickly, usually three to five minutes when given subcutaneously. The normal dosage is 0.1 mg./kg. or 5.0 mg. for adults. Animal and human studies suggest that apomorphine causes a more violent and more efficient emesis than ipecac. Apomorphine is, however, only available in the hospital setting, and thus its use is more limited than the readily available ipecac.

Since apomorphine is a respiratory depressant, it should not be given if the patient is comatose, if respiration is low and labored, or if the ingested poison is also a respiratory depressant. Apomorphine may produce pro-

tracted vomiting; this and some of its narcotic effects can be reversed by the administration of naloxone, levallorphan, or nalorphine.

Because apomorphine solution is unstable, it should be prepared immediately before injection. The solution is prepared by placing a 6 mg. tablet in a 5 ml. syringe and crushing it.⁹ Three (3) ml. of sterile water is drawn which readily dissolves the crushed tablet. Light and air can decompose these tablets, and thus they should be stored in a tightly stoppered, colored bottle. A green solution indicates decomposition and should not be used.

Other Emetics

Salt Water:

For many years salt has been regarded as a reliable and safe emetic. It is universally available in the home and can be fairly easily administered. Recent evidence suggests that salt is not only unreliable as an emetic but can, in fact, be dangerous. Hysterical parents have been known to give large amounts of salt to children unnecessarily. In some of these cases, the salt has become a more serious problem than the ingested agent. Several infant deaths have been reported from this type of behavior.¹⁰ Salt should NOT be recommended as an emetic.

Gagging:

Mechanical stimulation will only sometimes produce vomiting. Even when vomiting does occur, it does not very effectively empty the stomach. Gagging may, however, be used effectively in a patient resistant to vomiting after administration of ipecac.

Copper and Zinc Sulfate:

Both of these agents work by directly irritating the gastric walls. Hopefully, emesis occurs before there is more severe irritation and injury to the gastric mucosa. Vomiting usually occurs quickly; within 5-10 minutes. If vomiting does not occur, gradual absorption from the bowel may occur and cause systemic poisoning. Because of their toxicity, these drugs should not be used.

Mustard Water:

When prepared properly from dry mustard powder (not table mustard), this solution is sometimes effective. This solution is relatively safe. Lack of efficacy and waste of time to get a child to drink this unpalatable solution suggest that it should not be recommended.

Summary:

Emetics are useful agents to empty the stomach following an acute oral ingestion. Care must be taken, of course, not to neglect supportive therapy to induce emesis. For non-hospital use, syrup of ipecac is the emetic of first choice. This product may be sold over-the-counter in properly labeled one ounce containers. It is the feeling of the staff of the Maryland Poison Information Center that syrup of ipecac should be displayed in all community pharmacies, and the pharmacist on duty can play a major role in preventing morbidity by distributing literature on poison prevention and recommending to each parent with a child five or less that he purchase a container of syrup of ipecac and keep it in his home. Parents should be re-

minded that they should not decide to administer the ipecac without prior professional advice.

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Obituaries . . .

Nathan C. Card

Nathan C. Card, 88, died on December 4, 1973 following an apparent heart attack. He became a registered pharmacist in Maryland in 1909.

George E. Lee

George E. Lee, retired pharmacist and state official, died on December 28, 1973 at the age of 81. He graduated from Howard University School of Pharmacy.

Guy C. Kelley

Guy C. Kelley, 69, a 1924 graduate of the University of Maryland, School of Pharmacy, died on December 27, 1973.

Nathan J. Friedman

Nathan J. Friedman, 69, a 1925 graduate of the University of Maryland School of Pharmacy, died on December 20, 1973. Mr. Friedman was a member of the Maryland Pharmaceutical Association and father of pharmacist Julian Friedman.

U.S.P. Drug Defect Reporting Program

The Drug Defect Reporting Program was organized by the United States Pharmacopeia Convention in cooperation with the U.S. Food and Drug Administration and the American Society of Hospital Pharmacists. Recently the American Pharmaceutical Association joined the program and the program was expanded to include community pharmacists.

Pharmacists have been asked to report defects including inadequate packaging; confusing or inadequate labels or labeling; deteriorated, contaminated, or defective dosage forms; inaccurate fill or count of a drug product; faulty drug delivering apparatus; etc.

Information submitted to the U.S.P. is forwarded to the Food and Drug Administration and to the manufacturer involved. Depending upon the nature of the report more information might be requested. The U.S.P. periodically publishes information of interest resulting from these reports. The following are some examples of action brought about by pharmacists reports. No reflection on any particular manufacturer, distributor, pharmacist or product is intended or should be inferred from these case studies.

CASE STUDIES

A. Two reports were received about the fading in color of a blue coated tablet. When an F.D.A. inspector visited the firm he was advised that they were already taking action to eliminate the problem. The company concluded that the fading was due to storing the tablets (which are packaged in translucent containers) near a fluorescent light. The firm's spokesman noted that when the tablet containers were not next to a fluorescent light, or when other types of light sources were involved, no color change occurred. He also indicated that company tests showed that no safety or efficacy problem resulted from the tablet color fading. The firm indicated that they were proposing to change the packaging of the drug into opaque plastic bottles. Stability studies with the drug in such containers are currently underway.

B. Four reports were received about illegible labels and leakage upon reconstitution of the vials of an injectible anticholinergic drug. In discussing the problems with the firm the F.D.A. inspector was told that the firm had been aware of the problem and had already taken remedial action. All problems were associated with the shift of the firm's operations to a different site and using different equipment. Leakage of the reconstituted drug in the vial was caused by inadequate crimping of the aluminum overseal. Supplemental crimping procedures have been added and apparently have solved the problems. With regard to the illegible labels, a firm spokesman indicated that for a short period of time the preprinted silk-screened vials were not available and that they utilized a different labeling process. This proved to be inferior to the preprinted labels. With the preprinted vial again available, no further problem is anticipated.

C. A defect report was received in which the pharmacist indicated that he had some blue coated tablets used as a digestive aid in which, when the coatings were dissolved, a substantial portion of the tablet surface was brown rather than the expected white-sugared layer. When F.D.A. received the complaint they immediately noted that the tablet involved is normally red in color, rather than blue as described, and asked the District Office involved to check out the report with the pharmacist. The inspector was advised that the defect was called to the pharmacist's attention by a customer who had experienced no adverse reactions with the tablets. It was found that the reporting pharmacist had inadvertently written "blue", to describe what was in fact a "red tablet." A sample of the drug was collected by the F.D.A. inspector for analysis at the Los Angeles Laboratory to determine the cause of the mottled appearance on the tablet and to determine whether it presented a drug hazard. Upon analysis, the laboratory findings showed the active ingredient to be 99% of its labeled strength and the altered physical appearance of the tablet to be caused by excess moisture. The point at which the moisture was picked up was not determinable.

D. A report was received concerning potential confusion resulting from a hole punched into the label of a vial of Sodium Chloride Solution labeled in milliequivalents in such a location that it could have been mistaken for a decimal point. The company spokesman in discussing the problem, indicated that the hole in the label was used for label identity and that all labels for the same product have a hole punched in the same position. By coincidence, the hole in the label involved was positioned at a place where it could be confused with a decimal point. The firm has since switched to pressure sensitive labels and the hole code now appears only on the paper backing rather than on the label itself.

E. One report was received about Magnesium Citrate Solution N.F. with the quantity of contents molded "10 oz." into the bottle. The paper label indicated 340 cc. The bottle contained exactly 10 fl. oz. The firm's management said that before the receipt of the report from the U.S.P. they were not aware of the problem. Their supplier had trouble obtaining the larger bottle and switched to the more readily available 10 fl. oz. soft drink bottle. The firm did not notice the change and continued to use the regular label. They now are correcting the declaration as a result of receiving the report.

F. A pharmacist reported purchasing a liquid vitamin preparation in February 1971, which contained an insoluble precipitate that could not be redispersed. After receiving the report from the U.S.P., the pharmaceutical manufacturer checked its distribution records and informed the U.S.P. that the pharmacist had purchased this lot in 1965 not 1971. The firm also pointed out that the pharmacist had purchased the article ten times since that

time and recommended that the stock rotation of the pharmacy be improved.

G. A report was received from a California pharmacist that he had purchased Aminophylline Tablets U.S.P. that contained a strong ammonia odor which was indicative of decomposition. The pharmaceutical firm responded directly to the U.S.P. informing them that they had treated their reserve sample as described on page 7 of the Pharmacopeia under "odorless" by exposing the tablets for 15 minutes and that only a slight ammoniacal odor was observed. They also pointed out that the Pharmacopeia describes Aminophylline as having a slight ammoniacal odor.

The receipt of this information led U.S.P. staff to question the wisdom of including a test for odorlessness as a measure of the degree of odor. It also appeared desirable to include in the monograph for Aminophylline Tablets a section entitled "description" in addition to the description contained in the monograph for Aminophylline. The matter was submitted to the Revision Committee for study and action.

CASE STUDIES

A. The Academy of General Practice of Pharmacy of the A.Ph.A. reported to the U.S.P. the sale of plastic pen-shaped nitroglycerin containers to pharmacists for distribution to their patients. The U.S.P. notified the F.D.A. through the Drug Product Defect Reporting Program. Stability studies were conducted and a loss of potency was experienced. In one such container the loss was found to be as high as 50% in 24 hours, 70% in 48 hours, 80% in 72 hours, and 95% in 35 days. A recall was conducted. In addition, the U.S.P. and F.D.A. have proposed changing the packaging and labeling requirements for Nitroglycerin preparations.

B. A California pharmacist reported the crystallization of a commercially prepared solution of Potassium Iodide. The manufacturer wrote to the National Formulary informing them that the product was made according to the NF formula and that this is bound to occur if the solution becomes cold. The National Formulary in their 3rd supplement added the following sentence to their description:

"Crystals of potassium Iodide may form in Potassium Iodide Solution under normal conditions of storage, especially if refrigerated."

C. Two pharmacists reported the discoloration of an injectable Tetracycline Hydrochloride preparation. F.D.A. analysis of reserve samples revealed a low potency. The manufacturer was informed and cooperated by conducting a voluntary recall of the defective lots.

D. An F.D.A. inspection of one manufacturer was based on the receipt of a number of product defect reports concerning leakage or shortage of drug solution in single dose, rubber stoppered vials. The problem was traced to a mismatch of vial and stopper specifications,

and failure to employ adequate vial and stopper inspection prior to filling. The company indicated to the F.D.A. inspector that it has now instituted appropriate procedures for assuring proper matching and that they are expanding the number of samples they take for testing for leakage of vials as an additional safeguard.

E. This report concerns bottles of Methenamine Mandelate Capsules whose labels fell off. The F.D.A. inspector found that the drug firm had problems with labels adhering to glass containers, which were made in bottle molds purged with silicone, and not washed properly afterward. The bottle manufacturer has since improved his washing operation, and the drug company switched to a bonded adhesive for better label adhesion.

F. This report told of finding a flocculent white precipitate in vials of Bacteriostatic Sodium Chloride Injection U.S.P. When an F.D.A. inspector investigated the report, he found the company had already initiated an investigation. The company associated the formation with silicates from the type of glass vials used. To eliminate the problem, the company stated they were switching to Type I glass and had adjusted the pH of the solution.

G. This report included two problems; first the difficulty of reading the lettering used on a silk screened ampul label because of lack of contrast between the light blue lettering and the clear background. Second, the pharmacist noted that, although the drug was labeled correctly as Magnesium Sulfate 50% Injection, U.S.P., neither the label nor the insert provided the chemical formula so that the nurse or doctor could determine the actual amount of magnesium sulfate available. Magnesium Sulfate, U.S.P. includes 7 molecules of water of hydration for each molecule of Magnesium Sulfate; if this information is not known when calculating multi-equivalents, the result will be in error.

H. This report from a pharmacist estimated that 25% or more of the labels on Procaine Penicillin G Injection were not adhering to the vials. In checking with the firm, the F.D.A. inspector was informed that upon becoming aware of the label problem, the company requested return of all stock from their branch warehouses. It was the firm's opinion that the loose label problem was caused by the adherence of a silicone treating material to the outside of the vial container. Vial specifications called for silicone treatment on the interior of the vial to make it drain free. Apparently the silicone got outside causing the adherence problem.

I. This type of defect seems to be a common complaint. It concerns the problem of color fading when coated tablets are packaged in unit-dose, clear plastic "blister-packs". In this instance, the firm told the F.D.A. inspector that the fading was due to the fact that the dye used in the coating of the tablet was sensitive to sunlight and fluorescent light. Light exposure caused the fading of the color. The company has performed potency tests on several lots of the faded tablets and reports no effect on potency. They also indicated that they will pro-

(Continued on Page 16)

Some Principles For The Use Of Drugs

by

J. TYRONE GIBSON, Ph.D., Assistant Professor of Pharmacy, School of Pharmacy, Auburn University, Auburn, Alabama, and David S. Newton, Ph.D., Assistant Professor of Pharmacy, College of Pharmacy, University of Houston, Houston, Texas*

Introduction

Since society has designated pharmacy as the major custodian of legal drugs and since society can designate others to perform this task, pharmacy has a responsibility to society and to itself to see that society uses drugs properly. To this end, some pharmacists have found that providing advice on the use of drugs to lay persons, is one way at least partially fulfill these responsibilities. What follows is a brief discussion of some of the more important drug usage concepts which the lay person (and the health professional) should consider. This can be used by pharmacists as the basis of a drug usage talk for groups of lay persons:

Text of the Address

Understanding the basic principles pertaining to the rational use of drugs can enhance the use of drugs in such a way that improved health is promoted. The goal of drug therapy is to obtain a best match between a disease/symptom and a drug or drugs, i.e., a best match between conditions wrong with a person and a drug or drugs which are useful for treating these conditions. This goal is simply stated, but achievement of the goal is almost always difficult.

Most of us feel comfortable with our ordinary, everyday definition of a drug as a substance that either makes us feel better, gets us well, or prevents us from getting sick, or in some other way enhances our physical or psychological well-being. However, there are at least two other major ways to define the often used term, "drug." One definition is a legal one, and should first be considered from the point of view of those drugs that are legally available versus those drugs that are not legally available. The illegal drugs are known to many people and comprise such drugs as heroin, marihuana, LSD, etc. These drugs are outside the scope of this article. Legal drugs are, of course, those drugs that we can legally obtain from various sources in this country. There are several sub-classifications within the major category of drugs termed "legal drugs." These include prescription (legend), over-the-counter (non-prescription), new drugs, investigational new drugs, veterinary drugs, and controlled substances. The other major way of categorizing legally available drugs is the pharmacological category, that is, drugs categorized according to their effect on the body. Some examples of this way of defining a drug are

the appetite depressant drugs, sleeping medicines, antibiotics, anihypertensives (anti-high blood pressure), etc. For the most part, remarks herein relate to prescription and non-prescription drugs to be directly consumed by people.

The Marketing of Drugs

Within the several states, virtually no laws or regulations have been enacted regulating the determination of the effects of drugs. Instead, most state law regulates who can prescribe, dispense, administer, possess, and label drugs.

At the federal level an extensive network of laws have been enacted and resulting regulations have been promulgated. The most important of these federal requirements pertains to the requirement that any substance that has not previously been shown to be safe for use in people be proven to be both safe and effective for use in people before it can legally be marketed within this country. This (very briefly) entails the extensive testing of the unproven drug in animals to establish the extent of its safety prior to its testing in humans. The pharmacological effects of the drug will often be elicited as a part of the animal testing. Once the required animal testing has been satisfactorily performed, safety and effectiveness testing in humans must be completed if the drug is to be marketed legally. This testing consists of three phases. These are: phase 1, which involves the testing of drugs in one or more healthy persons; phase 2, which involves the limited testing of the drug in people thought to have the disease or condition for which the drug is proposed to be ultimately used; and phase 3, which consists of large scale trials (testing) of the drug in people having the particular disease or condition for which the drug is hoped to be effective in treating. The manufacturer's new drug application will be approved if all three phases of the drug testing are successfully completed. This means (when the new drug application is approved) that the drug has been proven, by the company marketing the drug, to be relatively safe and relatively effective for the uses, and only for the uses, listed on the label for that particular drug.

The last concept mentioned is extremely important when trying to understand the principles of rational drug usage. Drugs are safe only in a relative sense. That is, some bad or undesirable effects may occur from the use of any drug. However, the importance of these bad effects must be considered at the same time that the possible good effects are considered. For example, if one has a mild headache then he or she is willing to risk the "bad effects" from taking two, five-grain aspirin tablets which generally consist of nothing more severe than perhaps a little irritation within the stomach. However, if the person is suffering from a severe arthritic-like disease, then the person may be willing to undergo the probably increased risk of taking four or five aspirin tablets at one time in order to be relieved of the misery of this arthritic-like disease. This idea is of the utmost importance in

*The authors gratefully acknowledge the suggestions of Carl W. Driever, Ph.D., Associate Professor of Clinical Pharmacy, and N. John Hellums, J.D., Lecturer in Pharmacy Administration.

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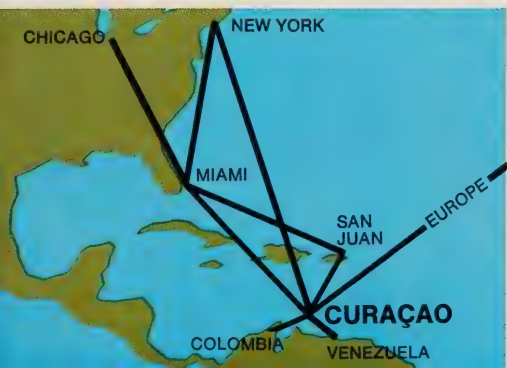
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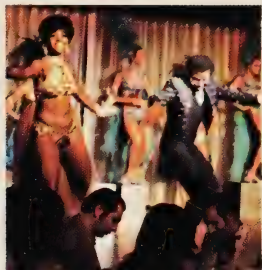


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understanding rational drug usage. Each and every drug must be considered to have both desirable *and* undesirable effects. For example, if a woman is considering using an oral "birth control pill," she knows that the benefit from use of this consists of not becoming pregnant and not having a baby. However, since all drugs, including the oral "birth control pill," are only relatively safe, she must consider the undesirable effects that may or may not happen to her as a user of this particular drug. These undesirable effects may consist of anything ranging from mild nausea to death. The likelihood of experiencing more significant side effects such as blood clots is less than the likelihood of experiencing less significant side effects such as nausea. She must take into account the chance or probability of these various undesirable events happening to *her*. This is best achieved through consideration of the best available information pertaining to the drug she is thinking about consuming.

Information Describing the Effects of a Drug

It is required that information describing the effects of a particular drug be categorized as described below. Each prescription drug sold in this country must contain the information described in the headings to follow. This information must be based on properly conducted scientific tests and must be approved by the U.S. Food & Drug Administration before it can legally be made available. Only pharmacists and physicians ordinarily have easy access to this information. The categories are as follows:

(1) The name of the drug —

This may consist of several different alternatives all referring to the same chemical substance. These names are legally termed "established name," but may also be termed "generic" name, chemical name, and research name. For example, cane or beet sugar (a food) has the established name of sucrose. Its generic name is sugar, but its chemical name is very long and cumbersome, namely, α -D-glucopyranosyl-beta-D-fructofuranoside, and if it was being used in a research project it might have a research name such as Delmonoco 25-3XY;

(2) The description of the drug —

This includes how the drug looks, smells, feels, dissolves, and also its chemical formula;

(3) Drug actions —

This category of drug information is concerned with describing the effect of a particular drug on various components of the body; e.g., the heart, blood, eyes, hair, skin, etc.;

(4) Drug indications —

This information category pertains to how the drug might be useful, e.g., relieve pain, prevent conception, prevent typhoid fever, cure "strep throat," etc.;

(5) Drug contraindications —

This refers to the conditions or reasons that may exist under which the drug should be used only if it is the last resort or under which the drug should not be used at all. Some examples of contraindications include: Do not use

during pregnancy; not to be used in persons less than 14 years old; not to be used by persons shown to be allergic to this drug; not to be used until treatment with aspirin has been attempted and failed;

(6) Drug Warnings —

This includes extraordinary hazards or undesirable effects of the drug that may occur, e.g., this may again include a statement such as safety for use in pregnancy has not been established, periodic blood testing should be performed, the dosage should be reduced in the elderly, and the like;

(7) Precautions —

This category relates to conditions that ought to be observed in the use and administration of the drug, e.g., to be injected into the muscle only, to be administered only by trained personnel, etc.;

(8) Adverse reactions —

This pertains to the undesirable effects that sometimes occur to people using the drug; e.g., nausea, sleepiness, skin peels off in layers, death, etc.;

(9) Dosage and administration—

This last category pertains to determination of how much of the drug to use and by which route, e.g., parenteral, oral, inunction (rubbing on), etc. Regardless of the route of administration, the ultimate effect on the body is generally the same if the blood level (concentration) of the drug is approximately the same. It is not true that if one tablet is good for a particular condition that two tablets will be twice as good for that particular condition. There is a particular number of tablets or a dosage that should be taken under ordinary circumstances for ordinary people. The importance of the rule for choosing the best dose cannot be overrated. The best dose for a drug is just enough to do the job, but not too much.

Some Suggestions for Using Drugs Rationally

A person should rely on information appearing on drug labels and not on advertisements; alternately, one can and should rely on information given by a competent person. The major reason that advertisements are less desirable than labels as a source of drug information is that the laws regulating drug labels are much more stringent than the laws regulating the advertising of drugs through the consumer mass media, e.g., newspaper, T.V., and radio.

Some basic assumptions of drug labeling are as follows:

- (a) the buyer can read the label;
- (b) the buyer will read the directions on the label;
- (c) the buyer will heed what he or she reads on the label.

A drug user should be careful to use drugs in accordance with these assumptions. Prescriptions should never be labeled "use as directed" or some similar wording. Over-the-counter (non-prescription) drugs cannot legally be labeled only "use as directed." Drug containers should

always be labeled such that the patient does *not* have to rely on his or her memory for taking or consuming the particular drug.

One should not share prescription drugs with others; that is, these drugs should be used only for the person whose name is on the prescription label. Do not expect drugs to be effective or good for treating too many illnesses; there is *no* effective drug for many of our aches and pains or sadnesses, tensions and anxieties. Drugs are generally effective only for treating clinical manifestations of disease and are occasionally helpful for alleviating the pain, suffering and discomfort of behavioral problems, but are rarely helpful for curing or relieving the discomforts of social problems. The latter category includes problems such as not liking one's job, children, self or some other attribute of one's daily life. It is very important not to expect drugs to do more than they can do. Drug quackery has thrived for centuries on unrealistic expectations from drug users—not only by laymen but by professionals, too. No matter how familiar one is with a given drug, he or she should never take this drug without first carefully reading the label prior to each and every time a dosage unit is consumed.

The above remarks can be helpful in assisting people to rationally consume drugs in their day-to-day drug treatment behavior. Our society is a drug oriented society. During any given 24 hour period, approximately one-half of the adult population in this country is under the influence of one or more legally available drugs. Many

of these drug usage instances may be inappropriate if the foregoing principles are not followed by the public. It seems likely that following these principles not only will improve one's health, but will also save the consumer money.

CASE STUDIES

(Continued from Page 13)

vide a precautionary statement on the "blister-pack" regarding the fading problem.

J. Many other reports were also received and investigated. Here are some examples of the kind in which neither the company nor F.D.A. could pinpoint the causes. We are including them to show the range of problems reported.

1. Disposable syringes which were not calibrated. (2 cases)
2. An empty, properly sealed, and packaged ampul.
3. A multiple dose vial with a neat hole in the glass.
4. A cap that would not stay on a nasal spray.
5. Crumbling tablets, although the reserve samples retained by the manufacturer showed proper hardness.

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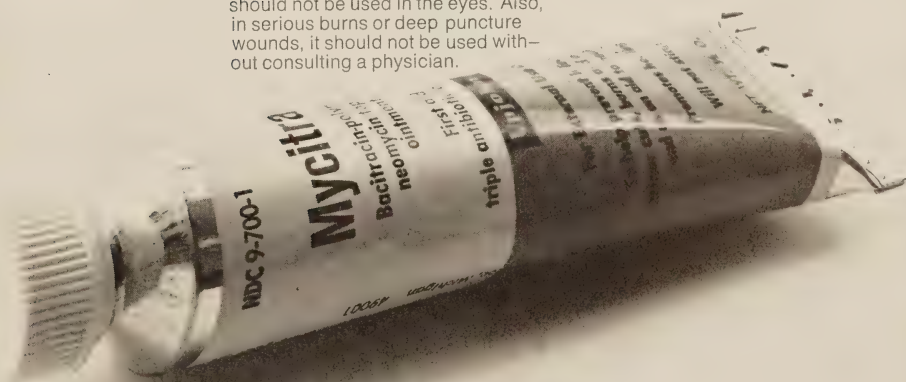
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Washington Spotlight For Pharmacists

By

APhA Legal Division

Oregon Marihuana Law

Last October, the Oregon Legislature abolished heavy fines and jail sentences for the possession of an ounce or less of marihuana. Possession of no more than an ounce of marihuana is treated similar to a parking violation, with a maximum penalty of a \$100 fine. No criminal record ensues. Possession of more than an ounce of marihuana may be treated by the court, at its discretion, as a misdemeanor.

Congressman Koch (D., N.Y.) stated in the U. S. House of Representatives:

... The only apparent difference between the "old" and "new" Oregon is that the police under the present law have more time to give attention to the real criminal elements and dangers to society and protect law-abiding citizens.

According to Mr. Koch, the Oregon law has received popular support from judges, police, and citizens of Oregon. Further, the Congressman has noted that there is no evidence that Oregon has become a haven for pushers and users of illicit drugs.

Congressman Koch and Senator Javits (R., N.Y.), a member of the President's National Commission on Marihuana and Drug Abuse, have introduced a bill to decriminalize private use and possession of small quantities of marihuana. Sale or distribution of marihuana for profit would remain a crime. Although many respected organizations, including the American Bar Association, the American Medical Association, the National Institute of Mental Health, and the National Commission on Marihuana and Drug Abuse, have indicated support for the decriminalization of the private use and possession of small quantities of marihuana, the Javits-Koch bill has received little support in Congress.

Methadone Clinic Mismanagement

The State of New York has obtained a court order requiring a clinic administering a methadone maintenance program to exercise greater control and supervision over their patients, both inside and outside the clinic. A number of residents and businessmen from the area near the clinic testified that patients of the clinic and other drug addicts congregated near the clinic, terrorizing the community with assaults, threats and boisterous vulgarities. Several witnesses testified that they saw these people pass small white envelopes from one to another, drink alcohol from bottles in paper bags and that these people were intoxicated and high on drugs and

HMO Bill Becomes Law

The "Health Maintenance Organization Act of 1973" was signed by President Nixon on December 29. The measure authorizes appropriations of \$375 million for fiscal years 1974-1978 and is designed to enable the federal government to help demonstrate the feasibility of the HMO concept. The new legislation authorizes planning and feasibility studies, payment of initial development costs, and funds to meet the operating deficits of HMO's during their first three years of operation. Prescription drugs are included in the law as a "supplemental health service" which means that HMO's may make a prescription drug benefit available as an option to members for an additional fee beyond the basic enrollment charge.

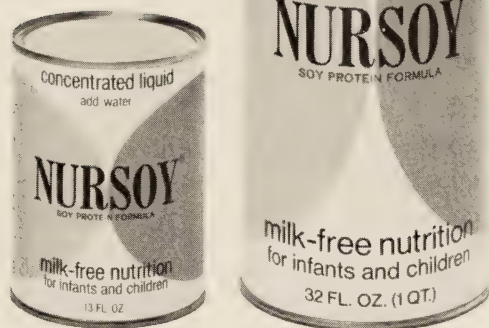
The legislation also authorizes an HMO to "maintain, review, and evaluate . . . a drug use profile of its members receiving (prescription drugs), evaluate patterns of drug utilization to assure optimum drug therapy, and provide for instruction of its members and of health professionals in the use of prescription and nonprescription drugs."

While the foregoing activities were recognized as functions of a clinical pharmacist in the original Senate HMO bill, the House version of the bill and the law as passed by Congress and signed by the President do not mention pharmacists. The joint conference committee which worked out differences between the Senate and House versions of the bill stated that it "did not wish to dictate the staffing patterns of each HMO and for that reason deleted language in the Senate bill which would have required the utilization of a clinical pharmacist as a part of the basic benefits package." The committee statement also said that the conferees were "cognizant of the important role the clinical pharmacist can play in encouraging the development of rational drug therapy programs for HMO's, and for educating patients and professionals in drug use and abuse, and urge that such professionals should be used to the maximum feasible extent."

loitered in groups on the street and in entranceways of apartment houses and stores.

The judge hearing the case concluded that careless and improper operation of the clinic caused injury to persons and property in the area near the clinic. The judge directed the clinic to use greater control and supervision over their patients, increase the security of the methadone in the clinic, and add more uniformed guards with instructions to disperse groups of two or more people loitering on the street in the vicinity of the clinic. The judge determined that the clinic should not be closed as he must consider the benefit to the patients and to the public in maintaining the methadone maintenance program.

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10 cases	40.60	35.00	46.80	11.80 (25%)	10 cases	37.10	32.00	43.20	11.20 (26%)
20 cases	81.20	70.00	93.60	23.60 (25%)	20 cases	74.20	64.00	86.40	22.40 (26%)

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University of Maryland School of Pharmacy

Shangraw To Study Norwegian Pharmacy

Dr. Ralph Shangraw, Professor and Chairman of the Department of Pharmacy, University of Maryland, School of Pharmacy, will begin a six month sabbatical on February 1. Dr. Shangraw will work with Dr. Per Finholt, Head of the Department of Pharmacy, Oslo School of Pharmacy, Norway, on research on bioavailability, the effects of formulation on drug action.

Dr. Shangraw is a member of the U.S. Pharmacopeia while Dr. Finholt is a member of a similar organization in Norway.

Dean Kinnard Featured on March of Dimes Message

Dr. William J. Kinnard, Dean of the University of Maryland School of Pharmacy, is currently being featured on the March of Dimes' statewide medical information line, "Dial-the-Doctor," with a message on the rational use of drugs and the patient drug profile.

The message, which will run for a two month period, is presented by Dean Kinnard for the Maryland Pharmaceutical Association. The March of Dimes "Dial-the-Doctor" is provided as a public service to all Maryland residents. Throughout the state, the message can be heard by dialing 1-800-492-9502, toll free. The caller may leave a question related to the topic which will be answered by Dean Kinnard through the mail.

Nominations Being Accepted For Honored Alumnus Award

Alumni are invited to submit nominations for the Honored Alumnus Award presented by the University of Maryland School of Pharmacy Alumni Association. Nominations together with a brief statement of information about the nominee should be submitted in writing to Ronald Sanford, Chairman, Honored Alumnus Award Committee, 1336 Denbriht Road, Baltimore, Maryland 21228. The award will be presented at the Annual Graduation Banquet in honor of the graduating class on May 29.

Dr. Thompson To Speak At Alumni Dinner

W. Leigh Thompson, M.D., Ph.D., Assistant Professor at Johns Hopkins School of Medicine, will be the principal speaker at the March 28 Alumni Dinner of the University of Maryland School of Pharmacy Alumni Association. The affair, which will be held at the Mercantile Club, 4801 Greenspring Avenue, Baltimore, will begin with cocktails at 6:30 p.m. followed by dinner at 7:30 p.m. For more information please contact any of the Alumni Association officers.

New Specifications For Digoxin Tablets Adopted

Standards and specifications relating to digoxin tablets have been revised and augmented several times during the past few years with the intent of providing greater assurance of uniform and predictable effectiveness and safety of this critically important drug.

In November, 1973, by way of an interim revision, the *U.S. Pharmacopeia* adopted a dissolution test and specification for digoxin tablets, and it is expected that batches of tablets not meeting this new standard soon will be recalled by the FDA.

Meanwhile, it is recommended that pharmacists keep a record of the lot number and manufacturer's name of digoxin tablets dispensed to each patient, as a source of such information in the event it becomes needed for recall purposes, dosage adjustment, or other reasons.

Dispersal of Controlled Drugs

The Green Sheet reports that dispersal of controlled substances among the stocks of non-controlled drugs maintained by community and hospital pharmacies to prevent theft or diversion is acceptable to the Drug Enforcement Administration. Locked cabinets are not necessary if there is no State law requiring them.

Noxell Corporation Reports New Highs In Sales and Earnings

G. Lloyd Bunting, Chairman of the Board and George L. Bunting, Jr., President, Noxell Corporation, reported year-end figures to stockholders indicating record sales and earnings had been achieved for 1973. In their report dated January 29, 1974, for the year ended December 31, 1973, the executives indicated the goals of the Corporation as set forth at the stockholders' meeting last year had been met.

Consolidated net sales for 1973 were \$91,850,000, an increase of 10.0% over 1972. Income before income taxes was \$13,819,000, a gain of 15.4%. Net income amounted to \$6,588,000, or 14.5% over last year. Earnings per share were \$1.30 compared with \$1.14 last year.

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Maryland Society of Hospital Pharmacists

The December meeting of the Maryland Society of Hospital Pharmacists was held at the Baltimore Student Union Building of the University of Maryland. The guest speaker was Dr. R. Adams Cowley, Director of the Maryland Institute for Emergency Medicine headquartered at University Hospital. Dr. Adams presented an interesting talk on the operation of University Hospital's shock-trauma unit and described future plans for a statewide emergency care network system.

It was announced that the Ninth Annual Hospital Pharmacy Seminar of the Maryland Society of Hospital Pharmacists would be held June 28-30, 1974 at the Williamsburg Motor Lodge and Cascade Meeting Center in Williamsburg, Virginia.

President Patrick appointed a committee to review the proposed establishment of a Pharm.D. program at the University of Maryland School of Pharmacy. The committee, chaired by Vincent dePaul Burkhart and including Kent Johnson and Samuel Lichter will review the proposed program to determine its impact on the practice of institutional pharmacy.

Hospital Pharmacy Profile Released

Pharmacy Times magazine has prepared a "Hospital Pharmacy Profile-1973" based on a survey it conducted in May 1973. The profile contains data on hospital pharmacy departments and on chief hospital pharmacists.

According to the report, the average hospital pharmacy dispenses about 55,000 inpatient prescriptions and 14,000 out-patient prescriptions annually. About one-third of all medication dispensed is in single-unit packaging, and most chief pharmacists think this proportion will increase.

The complete report is available for \$10 from Pharmacy Times, 80 Shore Road, Port Washington, N.Y. 11050.

Bowles to Receive Remington Medal

Grover C. Bowles has been named recipient of the 1973 APhA Remington Honor Medal, one of the highest awards in pharmacy. Dr. Bowles is Director, Department of Pharmacy, Baptist Memorial Hospital, Memphis, Tennessee. He is Treasurer of the APhA, first having been elected to that post in 1967. He is a past president of the American Pharmaceutical Association.

Presentation of the Medal will be made on August 6, 1974 at a Remington Medal Dinner in Chicago during the 1974 APhA Annual Meeting.

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Maryland Board of Pharmacy News

Pharmacy Changes

The following are the pharmacy changes for the month of December:

New Pharmacies

Dart Drug Corporation, Bryans Road, Herbert Haft, President; Route 210 and Route 227, Bryans Road, Maryland 20616.

Cumberland Nursing and Convalescent Center Pharmacy, Herbert S. Damazo; 512 Winifred Road, Cumberland, Maryland 21502.

Changes of Ownership, Address

Manheimer Pharmacy, Inc., Jacob Serpick, President (Change of ownership); 2502 Eutaw Place, Baltimore, Maryland 21217.

Hayman's Pharmacy, Inc., John J. Engberg, President (Change of corporation); Main and Lake Streets, Salisbury, Maryland 21801.

Linden Pharmacy, Charles A. Sandler, President (Change of ownership); 1701 Eutaw Place, Baltimore, Maryland 21217.

No Longer Operating As Pharmacies

Read's, Inc., Arthur K. Solomon, President; 501 Eastern Avenue, Baltimore, Maryland 21221.



—Photo by Paramount Photo Service

Melvin Rubin, left, incoming President of the Baltimore Metropolitan Pharmaceutical Association, gets handshake from outgoing President Paul Freiman.

Gilpin Elects Duncan To Senior Vice President

Ellis Elected Vice President

The election of Rutherford B. Duncan, Jr. to the office of Senior Vice President of The Henry B. Gilpin Company has been announced by James E. Allen, Chairman of the Board and President.

Mr. Duncan joined Gilpin in 1930 and, during his more than 40 years of service with the Company, he has held management positions in operations, sales, and marketing administration. Prior to his recent promotion, Mr. Duncan had held the office of Vice President, Administrative Vice President, and Vice President for Planning and Development.

The Henry B. Gilpin Company also announces the election of Robert R. Ellis, III, to the office of Vice President of Gilpin Wholesale Drug Company, a wholly-owned subsidiary with wholesale drug distribution centers located in Baltimore, Maryland; Dover, Delaware; Memphis, Tennessee; Norfolk, Virginia; and Washington, D.C.

Mr. Ellis is assuming this responsibility in addition to his present position of President of the Ellis-Bagwell Drug Company, a subsidiary of the Gilpin Wholesale Drug Company, with facilities in Memphis, Tennessee. His extensive background in the wholesale drug distribution industry in operations and management will contribute extensively to providing the highest quality service to all Gilpin customers.

Gilpin Appoints Cochran Corporate Controller

The appointment of Howard E. Cochran to the office of Corporate Controller has been announced by The Henry B. Gilpin Company, a distributor of health care products with headquarters in Washington, D.C. Mr. Cochran will be responsible for the corporate financial management and control of Gilpin's wholesale drug distribution facilities located in Washington, D.C.; Baltimore, Maryland; Dover, Delaware; Norfolk, Virginia; and Memphis, Tennessee, as well as McKenna Surgical Supply Inc., Sentry Drug Centers, Inc. and Point of Purchase Service Merchandisers, Inc., subsidiaries of The Henry B. Gilpin Company.

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Washington, D.C. 20013
(H. B. Gilpin Company)

APPEL, Bernard A.
50 Club View Lane
Phoenix, Maryland 21131
(Calvert Drug Co.)

BALTIMORE, Stuart L., Jr.
13 Acorn Circle, Apt. 101
Towson, Maryland 21204
(Maryland Blue Cross)

BINKO, Albert J.
328 S. Highland Avenue
Baltimore, Maryland 21224
(Binko Photo Labs)

BLOOM, Herman J.
2706 Geartner Road
Baltimore, Maryland 21209
(Paramount Photo Service)

BLOOM, Abrian E.
Box 368 Grasty Road
Baltimore, Maryland 21208
(Paramount Photo Service)

BOYLE, B. Dorsey
809 Stoneleigh Road
Baltimore, Maryland 21212
(Coca-Cola Co.) retired

BRADLEY, J. Murray
3 Dulaney Valley Road
Phoenix, Maryland 21131
(O'Connor & Flynn Realtors)

BRAGER, Maurice B.
3110 Marnat Road
Baltimore, Maryland 21208
(Brager Display Center)

BRENNER, Al
3811 Kilburn Road
Randallstown, Maryland 21133
(Albee Sales)

BRIGHTWELL, Ron
1022 Springhill Way
Gambrills, Maryland 21113
(Sandoz Co.)

BROWN, J. Donald
Box 217
Jarrettsville, Maryland 21084
(Bay State Assoc.)

BUFFANO, Tony
3606 Croydon Road
Baltimore, Maryland 21207
(American Greeting Card Co.)

BURGEN, Vernon A., Jr.
3214 Brendon Avenue
Baltimore, Maryland 21213
(Calvert Drug Co.)

BURNS, Thomas L.
707 N. Sterling Blvd.
Sterling, Va. 22170
(Lemming-Pacquin)

BURTON, W. Lloyd
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(American Greeting)

CAHILL, A. James
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Towson, Maryland 21204
(Monarch Life Ins. Co.)

CANTONE, Frank
2310 Carlo Road
Fallston, Maryland 21047
(Alberto-Culver)

CAPLAN, Joseph D.
80 Alco Place
Baltimore, Maryland 21227
(Southern Specialty Co.)

CERNAK, Melvin M.
8104 Clyde Bank Road
Baltimore, Maryland 21234
(Calvert Drug Co.)

CHEEK, John E.
1310 Putty Hill Avenue
Towson, Maryland 21204
(Parke Davis)

COHAN, Robert
91 Aquahart Road
Glen Burnie, Maryland 21061
(Nationwide)

CORNMESSER, John G.
9333 Millbrook Road
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(Borden-Hendler)

COSTANZA, Joseph A.
4906 East Federal Street
Baltimore, Maryland 21205
(Lucas Bros.)

CRANE, Richard E.
6007 Eurith Avenue
Baltimore, Maryland 21206
(Calvert Drug Co.)

CROZIER, John A.
13113 Manor Road
Glenarm, Maryland 21057
(Calvert Drug Co.) retired

CUMOR, Edgar G.
5722 Oakland Road
Baltimore, Maryland 21227
(Noxell Inc.)

DAVIDSON, Bud
6652 Sanzo Road
Baltimore, Maryland 21209
(Rita Ann Dist.)

DAVIDSON, John D.
3921 Minden Road
Wheaton, Silver Spring, Md. 20906
(District Photo Inc.)

DICKSON, Howard L.
8203 Boman Court
Towson, Maryland 21204
(Dunkin Donuts Co.)

DICKMAN, Arnold L.
3212 Marnat Road
Baltimore, Maryland 21208
(Pharmacist)

DIMOND, Walter
9173 Reisterstown Road
Owings Mills, Maryland 21117
(Eastern Drug Sales)

EBER, George Gilbert
10620 Partridge Lane
Cockeysville, Maryland 21030
(Sylvania Electric)

EDWARDS, Wayne C.
3429 Plumtree Drive, Apt. B
Ellicott City, 21043
(Sandoz Co.)

ENGEL, Frank
9603 Orpin Road, Apt. 104
Randallstown, Maryland 21133
(Loewy Drug Co.)

ESPOSITO, Carl L.
7811 Overhill Road
Glen Burnie, Maryland 21061
(Calvert Drug Co.)

ESTRIN, David J.
P.O. Box 2703
Washington, D.C. 20013
(District Wholesale Drug Co.)

EULER, Charles F.
309 Wakefield Place
Belair, Maryland 21014
(Nestle Lemur)

EUSTICE, Russell C., Jr.
17008 Woodale Road
Silver Spring, Maryland 20902
(Mid Atlantic Assoc., Inc.)

FAGAN, John H.
2302 Seminole Street
Adelphi, Maryland 20783
(Borden-Hendler)

FOLKEMER, Paul I.
9041 Chevrolet Drive
Ellicott City, Maryland 21043
(Folkemer Photo Service)

FORBES, John P.
13122 Dunbarton Drive
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(Murray-Coates)

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8411 Charlton Road
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(Block Drug Co.)

GAUSS, C. F.
13 Castlegate Court
Towson, Maryland 21204
(Mid-Atlantic Assoc., Inc.)

GEHRING, J. W.
3405 Greenway
Baltimore, Md. 21218
(retired)

GOLDSTEIN, Herbert B.
6016 Cross Country Blvd.
Baltimore, Md. 21215
(Miller Drug Sundry Company)

GOODMAN, Ben
7834 Kavanaugh Road
Baltimore, Maryland 21222
(Pharmacraft)

GRAUEL, L. Scott
Box 17 Fork Road
Baldwin, Maryland 21013
(State of Md.)

GROVE, William L.
Tall Oaks Apt.
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Baltimore, Md. 21234
(Calvert Drug Co.)

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(Whitman Candy)

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HENDLER, Bernard
Lord Baltimore Hotel
Baltimore, Maryland 21202
(Borden Hender Co.) retired, Honorary member

HOMBERG, Bernard F.
19627 Brassie Place
Gaithersburg, Maryland 20760
(Playtex)

HOWES, Edwin Wayne
111 Brookebury Drive
Reisterstown, Maryland
(Youngs Drug Products Corporation)

HUGG, Joseph J.
8404 Charles Valley Court
Baltimore, Maryland 21204
(Calvert Drug Co.)

JUSTIS, Swen
1313 Margarette Road
Baltimore, Maryland 21204
(Blueprint Co.)

KABERNAGLE, Edwin M., Jr.
503 Thornhill Road
Baltimore, Maryland 21212
(Dulaney-Vernay, Inc.)

KALLEJIAN, Leo (Doc)
Glenmount Towers, Apt. 409
Baltimore, Maryland 21212
(Beacon Janitorial Service)

KELLY, Eugene Paul
4 E. MacPhail Road
Belair, Maryland
(3 M Co.)

KENNY, John R., Jr.
13802 Summerhill Drive
Phoenix, Maryland 21131
(Read Drug Co.)

KOLB, William R., Jr.
12410 Melody Turn
Bowie, Maryland 20715
(Donington Sales Co.)

KOMMALAN, George H. A.
3 Edgcliff Road
Towson, Maryland 21204
(Borden-Hendler Co.) retired

KANE, Richard R.
1 Hillside Avenue
Baltimore, Maryland 21204
(Coca-Cola Co.) retired

KELLY, Thomas J.
203 Love Road
Somerville, New Jersey 08896
(Johnson & Johnson) Life member

KEPPLER, Milton J.
400 North Charles St., Apt. 1610
Baltimore, Maryland 21218
(Honorary member)

LEATHERMAN, A. G.
2 Ridge Road
Baltimore, Maryland 21228
(retired)

LEVIN, Julius
6805 Greenspring Avenue
Baltimore, Maryland 21203
(M. Levin & Son)

LEVIN, Phillip
P.O. Box 1657
Baltimore, Maryland 21203
(Loewy Drug Co.)

LEVY, Natt
424 West Franklin Street
Baltimore, Maryland 21201
(Coordinated Store Interiors, Inc.)

LEVY, Sherman E.
8607 Gray Fox Road
Randallstown, Maryland 21133
(Coordinated Store Interiors, Inc.)

LIEBERMAN, Arnold E.
216 Carnation Court
Baltimore, Maryland 21208
(Abbott Laboratories)

LOUD, Herbert G.
4 Glendorian Court
Cockeysville, Maryland 21030
(Hynson Westcott & Dunning)

LEVY, Louis
3311 Shelburne Road
Baltimore, Maryland 21208
(Honorary Member)

McNAMARA, Gary Patrick
5536 Lexington Road
Baltimore, Maryland 21207
(H. B. Gilpin Co.)

MAHONEY, Paul J.
141 Green Ridge Road
Lutherville, Maryland 21093
(Clorox, Inc.)

MARANTO, Charles A.
2819 Onyx Road
Baltimore, Maryland 21234
(Binko Photo Lab)

MATHENY, John C.
3121 Northway Drive
Baltimore, Maryland 21234
(Bay State Assoc.)

MAYER, Alexander M.
1101 North Calvert Street
Baltimore, Maryland 21201
(Mayer & Steinberg, Inc.)

MERVIS, David H.
3907 Glengyle Avenue
Baltimore, Maryland 21215
(Borden-Hendler Co.)

MANCHESTER, Carl C.
401 Allegheny Street
Holidaysburg, Pennsylvania
(Honorary member)

MESSINGER, Harry Otto
401 N. Wayne Avenue
Wayne, Pennsylvania 19087
(Kerr Glass Manufacturing Co.)

METZTOWER, Samuel D., Jr.
4710 Vicky Road
Baltimore, Maryland 21236
(Warner-Chilcott)

MEYEROWITZ, Joseph
3 Calgary Court
Randallstown, Maryland 21133
(H. B. Gilpin)

MILLS, Kenneth L.
8509 Drumwood Road
Baltimore, Maryland 21204
(Calvert Drug Company)

MULLEN, T. F.
121 Allegheny Avenue
Baltimore, Maryland 21204
(Financial Plans Corp.)

MUTH, Edward S., Jr.
6119 Bellona Avenue
Baltimore, Maryland 21212
(Retired)

MUTH, Joseph L.
207 Hollen Road
Baltimore, Maryland 21212
(Self employed—Real Estate)

NELSON, William L.
Box 48A Bottom Road
Hydes, Maryland 21082
(Brockway Glass Co.)

O'DONOVAN, John F.
304 New Jersey Avenue, N.E.
Glen Burnie, Maryland 21061
(Miller Drug Sundry Company)

OHLENDORF, Albert V.
1501 Cranwell Road
Lutherville, Maryland 21093
(Merck, Sharp & Dohme) Retired

PARR, Earl V.
1302 Saint Francis Road
Belair, Maryland 21014
(Eastern Drug Co.)

PHILLIPS, Gordon L.
3400 Westchester Pike
Newtown Square, Pennsylvania 19073
(Honorary Member)

PIPER, Edward W.
3811 Canterbury Road
Baltimore, Maryland 21218
(Honorary Member)

PLOWMAN, Paul B.
1821 Palo Circle
Baltimore, Maryland 21227
(Paul B. Plowman & Son)

POKORNY, William A.
309 Gralan Road
Baltimore, Maryland 21228
(Borden-Hendler Co.)

POSNER, Alan
5613 Northgreen Road
Baltimore, Maryland
(Loewy Drug)

RAAB, Frederick, W. Jr.
1831 Whiteoak Avenue
Baltimore, Maryland 21234
(Mid Atlantic Assoc., Inc.)

RADEBAUGH, Robert G.
8408 D Greenway Road
Baltimore, Maryland 21234
Medical Equipment & Supply Co.

RAICHLIN, Samuel
6107 Stuart Avenue
Baltimore, Maryland 21209
(Sir Sales Assoc.)

ROCKMAN, Louis M.
2 Amleht Court, Apt. 2A
Baltimore, Maryland 21215
(Barre Drug Co.)

ROCKMAN, Morris J.
3702 Copley Road
Baltimore, Maryland 21215
(Barre Drug Co.)

RORAPPAUGH, Laurance A.
609 Meyers Drive
Baltimore, Maryland 21228
(Murray-Coates)

ROBERTS, Brant E.
526 West University Parkway
Baltimore, Maryland 21210
(Honorary Member)

ROVNER, Maurice
4304 Park Heights Avenue
Baltimore, Maryland 21215
(Honorary Member)

SLAMA, Dr. Frank J.
348 Broadmoor Road
Baltimore, Maryland 21212
(Univ. of Md. School of Pharm.)
Retired

SPEDDEN, E. Donald
811 Seaward Road
Campus Hills, Towson, Md. 21204
(H. B. Gilpin Co.)

SPLKER, C. Wilson
1218 Boyce Avenue
Baltimore, Maryland 21204
(Calvert Drug Co.)

SULLIVAN, David T.
1 Dell Place
Laurel, Maryland 20810
(Becton-Dickinson)

STUART, James
9544 Muirkirk Road
Laurel, Maryland 20810
(Sandoz Co.)

TEABO, James E.
1543 Doxbury Road
Baltimore, Maryland 21204
(A. H. Robins Co.)

TEASS, George S.
513 Locksley Road
Baltimore, Maryland 21204
(Le Page, Inc.)

TURNER, E. Allan
5534 Cedonia Avenue
Baltimore, Maryland
(H. B. Gilpin Co.)

ULMAN, Bernard, Jr.
9212 Smith Avenue
Baltimore, Maryland 21234
(Bachrach-Raisin)

WATKINS, Francis J.
724 Camberley Circle, Apt. B1
Towson, Maryland, 21204
(Self-employed)

WEINER, David M.
3220 Greenmead Road
Baltimore, Maryland 21207
(Loewy Drug Co.)

WATERMAN, Richard H.
613 Orpington Road
Baltimore, Maryland 21229
(Retired)

WEYPRECHT, George C.
1615 Bluffdale Road, Apt. C
Baltimore, Maryland 21207
(Retired)

WILLIAMS, Ronald E.
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